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ADDRESS OF CHAIRMAN OF SECTION OF OBSTETRICS AND DISEASES OF WOMEN OF THE AMERICAN MEDICAL ASSOCIATION. (ABSTRACT.*)

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It is with much pleasure that I greet you on this occasion. I am grateful beyond expression for the honor you have conferred in selecting me to preside over your deliberations. It is indeed no small distinction to be honored in this way by so important a section of our national association, many of whose members have become known throughout the civilized world by the excellence of their work. No other country has furnished so many leaders in gynecological and abdominal surgery. They form a galaxy of bright stars in the medical firmament, and the history of this department would be incomplete without them. Imagine such a history without the names of McDowell, Sims, Dunlap, the Atlees, Battey and a host of others long since dead, and the many now living who are members of this Association, whose names have become household words. In the language of another, "gynecic surgery, with all its brilliant achievements, owes its position to the illustrious Sims, no less than abdominal surgery owes its origin to the world-renowned McDowell; and the outcome of the

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labors of these two remarkable men in beneficent results has no parallel in the annals of medicine." Surely we have a heritage which we should prize beyond my power of expression.

RELATION OF GYNECOLOGY TO OBSTETRICS AND SURGERY.

It has been claimed that obstetrics has not received the attention it deserves in our Section; that the teachers of obstetrics, with few exceptions, have offered papers on gynecological subjects, and as a result the proceedings have been scant in obstetrical literature. This has not been to the neglect of obstetrics as much as it would appear. Gynecologists have reached the highest perfection in aseptic and antiseptic technique. They have emphasized the importance of repairing injuries to the genital tract, and obstetrical operations have been devised and perfected by them. The two departments are so intimately associated that there is little in the one that does not concern the other and that is not necessary for both to know. It has been the application of surgical knowledge that has reduced the frightful mortality of the puerperal state. Such results as have been achieved at the Preston Retreat, of Philadelphia, and at similar institutions in this country and abroad, could not have been attained except by the practice of asepsis and antisepsis, together with such aid surgically as the gynecologist is best fitted to render. Patients in wealthy homes are not so fortunate as the poor in these well-conducted maternities. Physicians who seldom operate, with few exceptions, do not carry out a thorough technique. The habit must be formed. I would feel that this Section had accomplished enough for one session if it could impress upon them that the sterile rubber glove should be used in these cases. There is nothing required that can not be accomplished by the well-fitted gloved hand.

Some years ago the lamented Parvin, in his presidential address before the American Gynecological Society, earnestly pleaded for the combination of the chairs of obstetrics and gynecology in our colleges. He had published with his address a paper by Winckel, of Germany, in which this practice was eulogized. Winckel's claims were based largely on the fact that gynecology in Germany and Austria had been practiced first, with few exceptions, by the obstetricians. This was due entirely to national conditions. The great maternities of Germany and Austria furnish material for the obstetricians to find application for operations which the American, English and French surgeons had proved of value.

It has been said, "Obstetrics married surgery and the fruit of their union was bright-eyed gynecology." When it is remembered that more than 50 per cent. of the cases coming to the gynecologist for operation are the result of delivery, at term or prematurely, the need of obstetrics for surgery is only too apparent. It may be very justly claimed that the

specialty of gynecology resulted from the fact that the surgeon appreciated the situation; and to the surgeon more than to the obstetrician is due the exalted position of this department. I would not belittle the part the obstetrician has played in furtherance of this work, especially in the German and Austrian universities, but it was from the ranks of the surgeons that the first great workers emanated. In return this department, gynecology, has done most to bring surgery to its present high position. The gynecologists have achieved results in abdominal and pelvic work that never could have been accomplished by the surgeon who gave his time to general cases. As in all the special lines of practice and study, it requires a specialist to work out the delicate questions involved in this great field. It has been well said: "Most of the great advances of recent years have been made by them—specialists. They have perfected our methods, enriched our literature and filled our storehouses of knowledge. The reef they are constructing is no longer submerged in the dark waters of obscurity, but is now a mainland teeming with the fruits of their joint labors."

Dr. Geo. Ben Johnston likens the professional qualities of the true specialist to a massive pyramid, the finished capstone of which constitutes the specialty. "The pyramid of experience, learning and skill is a stable edifice, a pillar of strength which can not topple nor reel. In the case of the pseudo-specialist this pyramid of learning is inverted." Dr. Chas. A. L. Reed holds that specialism is manifestly to be even more distinct than in the past, while specialties, as known to the broad and progressive profession of American, will be able to gain recognition only by conforming to severer tests than are now applied; that it is safe to predict that in the not distant future "there will be fewer specialists, but, happily, better ones." He says: "The lines may, and possibly will, shift. Existing specialties, or certain of them at least, through the influence of further segregation and final equilibration, may, and probably will, disappear into the general profession, while segmentation will be inaugurated at other points to result in the development of other specialties. Thus shall the great future witness the mutations of progress."

Dr. Paul F. Munde, in 1898, in referring to the growing tendency upon the part of the general surgeon to encroach upon the field of the gynecologist, said: "We all know how long it requires and how difficult it is to gain the tactus eruditus by means of which an accurate diagnosis of pathological conditions in the female pelvis and abdomen can be made, and how liable even an expert gynecologist is to err in a doubtful case. How, then, can the general suregon, with all due allowance for his skill and dexterity as an operator, expect to rival the expert gynecologist in the field which the latter has made his special study." He further says that he has seen general surgeons, to whom he would unhesitatingly intrust his patient for an operation in any other region of the body, make woful

blunders when attempting to carry out the operative indications emanating from their mistaken application of a purely gynecological case.

The exalted position which gynecology occupies in this country is owing largely to the medical journals devoted to this department, and to the national special societies, of limited membership, whose transactions have gained world-wide reputation. It was a great step when the American Gynecological Society was organized in 1876. Membership in this society meant ability and worth and guaranteed recognition at home and abroad. Later the American Association of Obstetricians and Gynecologists was formed after a similar plan, with like results. In 1887 the Southern Surgical and Gynecological Association was formed. At first this union of surgery and gynecology was questioned by many, but it is acknowledged now by all that it was a fitting and proper union.

PROGRESS IN GYNECOLOGY AND ABDOMINAL SURGERY.

The development of gynecology has witnessed many errors and extremes in practice; but with so many earnest and able workers seeking the truth, it required only time to settle many questions at issue and secure the adoption of safer lines of procedure. Much of Sims' work was found to be erroneous; many of the cervices he slit had to be repaired. Battey's operation was a monstrous mistake; yet the value of his pioneer work in pelvic surgery cannot be overestimated. He had no conception of pelvic pathology and removed normal ovaries to establish the menopause, because it had been observed that patients frequently were better after they had ceased to menstruate. I knew Dr. Battey well, and had exceptional opportunity to follow many of his cases. While he thought these nervous cases were benefited by the operation, the unbiased observer could not fail to appreciate his mistake. Think of the countless operations performed by less capable operators than Battey for nervous symptoms, removing normal ovaries. His teachings have resulted in more harm, perhaps, than those of any other one gynecologist. On account of his erroneous and radical teachings the neurologists went to another extreme and have failed to give surgery its proper place in the relief of nervous symptoms by the removal of pathological conditions in the tubes and ovaries.

The French gynecologists, not being permitted for a long time to do abdominal operations, undertook too much by the vaginal route and sacrificed countless uteri and ovaries unnecessarily. In order to reach the pelvis by the vagina it became necessary to remove the uterus to furnish a satisfactory route. A few of these distinguished gynecologists have come across the waters to teach the Americans French methods, and instead have learned that the abdominal incision is the preferable route by which to deal with the majority of the conditions in the pelvis. In their operations for pelvic inflammation they often found themselves unable

to remove the tube and ovary after the uterus had been extirpated in cases cured by the operation; yet they did not learn from this that a vaginal section with thorough drainage might have accomplished the same without hysterectomy. Too much has been claimed for vaginal section, yet it has a wide field. Peritubal and periovarian abscesses of large size, from whatever cause, should be drained by the route, and later abdominal section done, if found necessary. The uterus, of course, should be curetted before the abdominal operation. In this way the appendages on one side can in a majority of cases be saved. Puerperal pelvic inflammation occurring in the first month or six weeks after delivery should be dealt with by vaginal incision. If the abscess is small all adhesions should be broken up, and the diseased tube thoroughly opened, followed by gauze packing. A large percentage of such cases will be cured and some will bear children afterward. Cases of puerperal inflammation should be operated on without waiting for pus formation. By early section and drainage convalescence is hurried. My experience in cases without pus has not been large, but exceedingly satisfactory.

The extremists for a time advocated hysterectomy for all uterine fibroids that could be found by the most searching examination, and there are some now—the same ones, I believe—who practice myomectomy in a class of cases that the great majority of gynecologists very properly consider suitable for hysterectomy. There is no reason for the sacrifice of the uterus when the tumors can be enucleated without mutilation, but it is mere sentimentalism to try to save organs when greatly mutilated.

Uterine cancer has furnished a field for another extreme in practice. It has not been shown that the extensive operations recently practiced have accomplished more than hysterectomy, going wide of the disease. If it has passed much beyond the uterus, palliative operations are attended with better results than the radical ones. However, I hope that the discussion to take place at this meeting will throw valuable light on the management of these cases.

It is gratifying to note the increasing popularity of the round ligament operation for retrodisplacements of the uterus. I am impressed that few operative procedures without danger are capable of furnishing so much relief. Cases should not be encouraged to wear pessaries when so simple an operation would give relief. If intra-abdominal conditions prevent the extraperitoneal operation the abdomen should be opened and the ligaments shortened by an intra-abdominal method.

Much honor is due Kelly and others for their work in exploring the bladder and ureters, but it is carrying refinement too far when it is attempted to treat pus in the kidney through the ureter. A lumbar incision is too simple and free from danger for such methods.

The surgery of the gall-bladder has advanced little beyond Marion Sims' operation in 1878. No department of surgery has been attended

with better results than operation on this organ. While its surgery is about settled, the surgery of the ducts is still under discussion. In the spring of 1893, I undertook some experiments, which I reported the same year to the Surgical Section of this Association, and was convinced from these experiments that it was unnecessary to stitch the duct after the removal of stone; that gauze-drainage and a glass tube would take care of the bile, even though infected. This operation without stitches had not been done at that time, but since then a sufficient number of cases have occurred to demonstrate the advisability of the procedure. I quote the following from a paper by Dr. W. D. Haggard, Jr., at the New Orleans meeting, 1899, of the Surgical and Gynecological Association, as evidence in favor of the operation:

"If it is inexpedient to suture, the entire efficacy of drainage with gauze has been abundantly proved and its employment ardently insisted upon by W. E. B. Davis. . . . The importance of this suggestion is well illustrated by a recent report. Quênu collected 95 cases of suture of the ducts with a mortality of 35.5 per cent., while the mortality of the cases without suture was only 18 per cent. In these were includeed six personal cases. In two sutures were used; both died. In two others biliary intoxication appeared, the sutures were cut and the patient recovered. The other two were not sutured and recovered. Fenger also believes the common duct should not be sutured as a rule, and never without drainage, both from the site of incision in the duct, and particularly drainage of the gall-bladder to prevent biliary intoxication."

This procedure should make the surgeon feel very secure in these operations, as it is almost impossible to stitch the duct satisfactorily in many cases.

The methods of stitching the abdominal incision have not proved entirely satisfactory. Animal sutures may give way, causing trouble, and non-absorbable material, if buried, may have to be removed. I have been using a method which commends itself in a considerable percentage of cases. The tier suture with absorbable material has a high place in surgery, but the majority still close the wound by the interrupted through and through suture of non-absorbable material. The method described possesses the advantage of both, and obviates some of their objectionable features. I use interrupted sutures of silkworm gut, uniting the aponeurosis, recti muscles and peritoneum, and secure the sutures by means of very small silver tubes, corresponding in length to the thickness of the skin and subcutaneous fat, through which the ends of the suture are passed, and then through a perforated shot. After the aponeurosis has been well approximated, each tube is pressed well down and secured by the compression of the shot at the distal end of the tube. After all sutures have been secured, the skin is brought together with a very small suture of silk or catgut. The suture should be very superficial or sub-

cuticular. The little tubes with shot project just beyond the wound. Compresses of gauze are placed on the sides of incision to approximate the subcutaneous fat.

The silkworm gut sutures should remain from two to three weeks, and may be removed by clipping the ends of the sutures between the tube and the shot, and after the tube is removed the suture comes without difficulty. By this method the wound is free of all foreign material before the patient is discharged, there being nothing left to cause subsequent trouble. The method has a wide field of application.

In conclusion, I may say we have reason to regard the future of this Section, and of the Association of which it is a part, most promising—in fact, brighter than ever before. Much has been accomplished in making the editor of The Journal secretary of the Association. There yet remains one source of regret to all, and that is that the New York State Medical Society is not in affiliation with the Association. Let us hope that the time is not far distant when it shall be otherwise.

OPIATES AND ETHICS.

By Barton W. Stone. M.D.,

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After a year ago, in the city of Nashville, I was called to give an opinion in court as to the legal responsibility of a morphine habitue, a teacher, who had administered a fatal dose of morphine to his wife. He tried also to end his own existence by the same drug. He was on trial for the murder of his wife. The couple had always lived harmoniously; each was above 50 years of age, and very intellectual. Disappointments in business led to the contemplation of the double tragedy. There was collateral evidence adduced, which proved the man's mental eccentricity, but a directly contributing cause of his dreadful deeds was his habitual use of morphine. He suicided a year subsequently. This is an extreme case, but it is well known that the abuse of opiates leads generally to reckless views of the value of human life and to reckless employment of the drug.

A morphine habitue in the Purchase of Kentucky gave a friend who had delirium tremens an enormous and fatal dose of morphine to induce sleep. He was tried for murder but the court, convinced of the man's good intentions, and the absence of the semblance of malice, dismissed the case. There is usually little remorse after the commission of crimes of this character. Instances like the above are frequent, besides lesser crimes, of all kind except adultery, resulting from the debauching influence of opium addiction. The omission of adultery from the category demonstrates the degenerative character of the changes produced upon the physical constitution.

A few doses of opium taken by a person who has never indulged habitually in its use do not perceptibly affect the moral nature. But when repeated doses involve him in the toils of a habit from which he finds it difficult to extricate himself, he realizes, often suddenly, that his integrity of morals and manliness have suffered impairment; and, like Adam and Eve, after having partaken of the forbidden fruit of Eden, he begins systematically to hide his deformity of character. Opium so transforms the moral constitution of the habitual user that, whilst he may be able to clearly distinguish right from wrong, truth from falsehood, he becomes indifferent as to the consequences of making proper choice between them in governing his conduct.

I probably have no right to say that the morphine habit has this corrupting influence upon the morals of every subject. I am sure there must be exceptions to this almost universal rule. Perhaps I should except the aged saint, who, to ease the pains caused by rheumatism or senile degenerative changes, has been induced into the opium habit by a well-meaning physician. It is, however, suggestively common with even this class to prate ostentatiously of Scripture, religion, and especially of their own spiritual triumphs, and even sanctification. Possibly some clergymen do not become liars, like lawyers and other public speakers, who have become habitual users by employing it to stimulate brain activity for special oratorical efforts. But the fall of many a minister has commenced right here.

When I say that I cannot impeach the veracity and general integrity of all opium habitues, nearly every one with whom I have become acquainted will want to be left out of my indictment. Each will acknowledge that opium engenders mendacity, but claim that in his particular case there no occasion for lying, etc. I have never known one to make an absolutely clean breast of his failings. A Kentucky Judge recently threw out the testimony of a witness in an important case when he ascertained that he was a morphine habitue.

Dishonesty of speech is naturally akin to dishonesty of action. A good per cent. of morphine habitues will commit theft if a favorable opportunity offers; but wholesome respect for public opinion and fear of the law lessen the number of crimes of this character. Besides, a large proportion of subjects are well-to-do, and the temptation to theft is accordingly less strong. Light regard for property rights, is however, very generally an effect of the habitual use of opium. A further effect is the loss or weakening of the sense of religious obligation. Blatant skepticism is occasionally seen, but more frequently there is a pretense of possessing a higher type of religion than is ordinarily claimed, each evidencing moral alienation. Very early there is a loss or material diminution of reverence for age, civil and parental authority, conjugal love and genuine friendship. There soon comes indifference as to breadwinning, and indisposi-

tion to exertion, in order to provide sustenance for the family, or even self.

The use of opium often destroys the fetus in utero. A lady came to my sanitarium to be rid of the opium habit, solely because she did not want to commit the crime of killing her unborn child. She had just discovered her condition of pregnancy. I have been informed that opium has been often used to procure abortion. The punishment for the crime in the forming of an opium habit seems a just one.

In the common course the opium-user becomes lazy, self-indulgent, absent-minded, conceited, garrulous, sensational, and a mischief-making gossiper. The slavery of the habit grows stronger day by day. The constant mental occupation of the subject is as to the degree of comfort derived from the last dose, and the length of time until the next one is due. By slow stages the habitue settles into comparative imbecility, never losing, however, a marked degree of shrewdness in acquiring and storing opium for the daily need. The moral nature becomes thoroughly depraved; insincerity, duplicity, and downright dishonesty enter into every thought, word or action, painfully patent to every one.

With all these ethical effects of morphine, there have been taking place degenerative changes in the physical constitution. The nervous system, alimentary tract, the kidneys and liver under the poisonous action of opium, gradually lose function. Finally the miserable, suffering, fruitless life gradually goes out.

A common characteristic of probably all narcotics is that the dosage must be gradually increased to bring the desired degree of comfort. I do not believe the oft-repeated story of the habitue, who lived to a happy old age, never having increased his daily portion. If true, it would show that he could have lived just as comfortably without any opium, and so escaped its slavery.

It is common for opium users to experiment with all other stimulants and narcotics that may be available, and thus in manifold degree lessening their chances of being liberated from the chains of habit. Alcohol, chloral and cocaine are more frequently combined with opium than any other drug. Cocaine entails the direst consequences upon the mental constitution. The majority of cocainists early develop positive insanity, usually of the paranoiac type, and of very insidious and dangerous character. About four years ago a Nashville cocainist shot to death his father, a distinguished jurist. He had the delusion that his father was conspiring to kill him. Another subject fancied that his mother and others were preparing to kill him. He was detected in making arrangements to burn the residence or to destroy it with dynamite, was put in jail, and afterwards sent to the County Asylum. He tried to burn both the jail and asylum.

The mental effects of cocaine sometime persist for months after the

drug has been withdrawn. The will power is always weakened, and this explains the specially strong liability of the cocaine-user to relapse, after having ceased taking the drug. Another cause of relapse is that quitting the habit is attended with very little pain.

Like cocaine, alcohol also weakens the will, this constituting the element which renders its association with the morphine habit so unfavorable, a few drinks of alcohol generally re-exciting an irresistible appetite for opium. The association of two habits quadruples the gravity of the case.

The morphine habitue recurs to his habit more to relieve his pain than to derive pleasure; the cocainist to experience the delights which the drug brings. Under its use the public speaker has his courage and his wits increased. The writer may work for 48 hours without food or sleep. It powerfully stimulates failing physical energy, and makes the pauper as happy as the king. Some day, however, there must come a reckoning and compensation for all this over-stimulation. Mental, nervous and general physical impairment are sure to follow the abuse of cocaine or any other drug which has like effects. Many proprietary so-called nerve tonics contain cocaine or kindred drugs. Are we safe in prescribing such remedies as wine of coca, vin mariana, coca-cola, bromidia, and numerous other lauded articles? Cocaine, morphine or other narcotics are, I am informed, incorporated with various proprietary medicines and even soda-font beverages and cigarettes, to stimulate repurchasing. Thus are the dangers increased which beset the uninitiated as well as the reformed habitue.

The picture presented of the dreadful effects of opium should stir the physician especially to try to stop the terrible abuse. I would reproach myself if I had inoculated any person with cancer or tuberculosis. I would be equally as culpable if I should unnecessarily fasten upon him the habit of using morphine, and, considering its moral, as well as physical entailments, I would be more culpable.

It may be safe for the physician to prescribe the drug in combination with other medicines for protracted periods, or morphine alone for a few days, but I believe the patient should be kept in ignorance of the fact that he is taking the drug. It should be used, however, as seldom as possible, and the profession should warn the laity of the dangers in using it or any other hypnotic or stimulant.

I regard it as impossible to prevent the purchasing of opium. But druggists may do much toward lessening its consumption by kindly warning and advice, and by refusing to refill prescriptions containing narcotics without orders from the physician. It would be a refinement of cruelty if a patient sought for relief of physician and druggist, and, all unawares, should have a morphine habit foisted upon him, or having "asked a fish, they should give him a serpent."

A morphine habit well established is usually a hopeless condition, unless the aid of powerful restraining measures is invoked, such as cannot be attained at the subject's own home. The Massachusetts State Board of Health ascertained by analysis that nearly all the so-called "opium cures" contained opium or its alkaloids, and are not better, but often worse in their effects than the pure opium uncombined.

Under proper management many subjects are weaned from the habit, but the tendency to recur to it is very strong. In such cases strychnine exercises a useful bolstering influence upon the weakened will. But the evil is best met before the habit is formed. The law-makers should be enlisted against it. Whilst the enactment of laws against the indiscriminate sale of morphine can never suppress it, it might mitigate, and at least emphasize a wholesome public warning against the formation of the morphine habit.

The Chinese began using opium in the seventeenth century. Their present recognized national degeneracy is generally attributed to its widespread abuse by all classes. More opium is used by them than by any people in the world. The imperial government has repeatedly attempted to enforce an embargo against its importation into China. The attempts have all been unsuccessful, mainly through the opposition of the European commercial nations. Treachery, cowardice and homicide are very common traits in these people. Fortunately the Chinese adopt the least injurious form of using opium, viz—smoking. I have had less trouble in removing this habit than any other form of opium taking. The cooking process of the extract of opium, in preparing it for the pipe, doubtless removes from the drug part of its poisonous quality.

Notwithstanding all the warnings against opium using, the drug is as often prescribed now, and as freely used as it ever was. In spite of the demonstration of the evil effects upon the users and the usual neurotic heritage entailed upon their progeny, new victims present themselves every day. In spite of their experience of suffering and slavery the old habitues will very often seduce their best friends, even members of their own families, into the habit, and the reformed habitues will in considerable numbers return to their habits, like the dog to his vomit, or the sow that was washed to her wallowing in the mire.

NOSOPHEN AND ANTINOSINE IN THE TREATMENT OF DISEASES OF THE NOSE, THROAT AND EAR.*

By Edwin Pynchon, M.D.,

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Occasionally one sees the excellent handiwork of some old sailor, and is fascinated thereby, it being perchance a perfectly formed and fully rigged miniature ship, and, after having admired and praised both its symmetric form and excellence in detail, is told that it was whittled out by the old sailor with the use of only his jack-nife. With me, while fully appreciating the excellence of such work, I am always reminded that if the sailor could do so well with so simple a tool, other things being equal, he should be able to do much finer and more elaborate work were he provided with a more modern and extensive working outfit. In fact, fine tools and instruments of precision are required by the skilled artisan in the execution of highgrade work and for the production of his masterpieces. In the same way in medicine, the finest results are attained by a careful selection of the best obtainable agents or remedies, and the aim of the latter-day manufacturing chemist is to produce synthetically, for the use of the physician, a line of remedies, each of which, while possessing some characteristic therapeutic property, is freed from those objectionable qualities which were in one way or another so often met with in its more crude predecessors of even a decade ago.

While for many centuries iodine and its salts have been valued chiefly as internal remedies, the use of iodine externally has been materially increased since the discovery of iodoform in 1822. Iodoform is an example of the cruder products of by-gone years, as previously alluded to, and it has fallen into disrepute owing to its disadvantage in the way of odor, and also through certain toxic manifestations which are not infrequently produced by its employment. When used in the oro-nasal cavity iodoform is more annoying to the patient than when used in other localities, and is at the same time equally repulsive to the patient's associates.

Many attempts have been made to produce a substitute for iodoform possessing its valuable antiseptic properties minus its disadvantages. I have for some time been using nosophen in this connection and have found it to be the ne plus ultra of remedies of its class. It is produced by a peculiar chemic combination of iodine and phenol obtained by the action of iodine on solutions of phenolphtalein, and constitutes a non-decomposing molecule which in its action upon moist living tissues be-

*Lecture delivered before the class of the Chicago Eye, Ear, Nose and Throat College, October 27th, 1899.

comes a soluble albuminate. The formula of the compound would naturally suggest strong germicidal properties.

Besides being odorless and tasteless, nosophen is likewise non-toxic, owing to the fact that while in its composition iodine to the extent of nearly 62 per cent. is employed, it is so firmly united in the compound that it does not become liberated in use. In this respect it may appropriately be contrasted with iodoform, which decomposes in the body, liberating free iodine, and therefore has a great tendency to produce toxic effects, and sometimes a dermatitis, particularly in cases wherein a scrofulous dyscrasia exists. In its use nosophen is gradually converted into soluble antinosine by the alkaline fluids of the body, and by being thus slowly dissolved keeps up a continuous antiseptic action until its eventual and complete dissolution is attained. The modus operandi of its antiseptic action is that the antinosine, as released from the nosophen, combines with the albumenous elements present, forming soluble iodo-albumenates, upon which, for nourishment, the bacteria cannot thrive. Hence, as an antiseptic, nosophen is not a direct death-dealer to the bacteria as is bichloride, but exerts its influence in a less direct, though equally effective manner by causing their death through starvation. In its local action, nosophen is deodorizing and absolutely non-irritating when applied, no matter how liberally, and, being furthermore neutral in reaction, and of light specific gravity, is an ideal dusting powder in general surgical practice. If taken internally, it is excreted unchanged as nosophen. Owing to their molecular stability, nosophen and its salts have no extended list of incompatibles as have agents the molecules in which are easily disintegrated.

Nosophen, like aristol, is decidedly drying when applied to suppurating surfaces, though its property of solubility gives it a marked advantage over the latter when used in a cavity like the tympanum, which should never be clogged by any insoluble powder. Both aristol and boric acid, which have been so extensively used in otologic practice, have a tendency to harden or cake.

In addition to its antiseptic property, and secondary thereto, owing to its control of inflammation, nosophen becomes slightly hemostatic and also somewhat anesthetic or sedative. In this latter respect it stands in contrast with boric acid, which occasionally produces pain when insufflated in the middle ear, and is furthermore at best but a weak antiseptic.

Antinosine is the sodium salt of nosophen and is of a blue color when in the powder form, though, when dissolved in distilled water, it makes a clear port-wine-red solution which varies in shade according to the strength of the solution made. In some strange way the erroneous statement is frequently met with in the literature of this agent that the watery solution thereof is blue. A solution of antinosine, if exposed to the air will in a few days, through absorption of carbonic acid, change to a reddish-

brown color, owing to the precipitation of nosophen, though it can be readily returned to its former state by boiling. While the color of the solution is so pronounced it does not permanently stain any washable fabrics, and all stains made can be easily removed by ordinary laundry methods. The permanency of aqueous solutions of antinosine is increased by the addition of a small amount of glycerine, say 5 or 10 per cent. Antinosine is used in solutions of a strength of 1,2000 up to 3 per cent, or even stronger. In making an aqueous solution, distilled water should be used, as the organic matter in ordinary cistern or hydrant water is incompatible with the antiseptic, and makes a solution of darker color than when distilled water is employed, though, while its action is thereby somewhat impaired, it still retains considerable antiseptic power. Antinosine is soluble in alcohol to the extent of two per cent., and in glycerine up to a strength of about ten per cent. It is slightly styptic to the taste.

Nosophen, and its alkaline salt antinosine, are not decomposed by heat up to any temperature below 220 degrees C., which is equal to 428 degrees F., and is of course a much greater heat than the agents would ever be exposed to in ordinary use. If desired, the presence of iodine can be easily demonstrated by the following simple test: Make a small cone of clean white blotting paper, fastened with a pin, and wet in with a cold aqueous solution of starch. Next heat to a dull red a thin sheet of iron and throw upon it a pinch of nosophen. Fumes of iodine will at once rise, which, if imprisoned by the cone, will produce therein the characteristic iodine-starch reaction. The same may be done with antinosine, with the same result, though fusion occurs less rapidly than with the nosophen.

In the literature of nosophen the statement is frequently met with that it is "freely soluble in alkaline solutions." As antinosine is the sodium salt of nosophen one would naturally be led by this statement to select a solution of sodium bicarbonate when, for example, desirous of washing off from a wound any nosophen remaining from the last treatment. Nosophen is not soluble in a solution of sodium bicarbonate at ordinary temperature, though when the same is heated to the boiling point the nosophen dissolves and the solution becomes purple in color. The same is true with solutions of potassium bicarbonate and sodium biboras. Nosophen, however, is more or less soluble in the following mediums at ordinary temperature; aqua calcis, aqua ammonia, liquor potassae, and the aqueous solutions of caustic soda or potassae carbonas purus. In each case a purple color is produced.

Antinosine can be used as a substitute for bichloride in many cases, being used as a douche in a strength as weak as 1-2000 when the fluid is constantly moving, while on the other hand, when the solution employed is at rest, as when applied upon cloths or with a cotton applicator, a

strength as great as three per cent. may be required. Its non-poisonous quality is in strong contrast with any of the antiseptic mercuric salts.

Antinosine, full strength, when applied to an open wound is a powerful and stimulating antiseptic, which causes a free discharge, though accompanied by much irritation, if not positive pain; hence its use when undiluted should be limited to small areas. As dermatologists have, with benefit, thus employed antinosine in full strength as a powder application to venereal and lupoid ulcers, and furthermore, as in its use the antiseptic action of nosophen is entirely due to its being gradually transformed into antinosine, it occurred to me that it might be advantageous in some cases to intensify the action of nosophen by combining with it different per cents. of antinosine as indicated. This I have done and am pleased with the results. The mixture of nosophen and antinosine in different proportions has proven to be a stable compound when kept in the usual closed container, and is, as far as I have been able to observe, free from objection, with the advantage of thus intensifying, both in strength and activity, the therapeutic power of the plain nosophen. Furthermore, the solubility of the nosophen is thereby accelerated, which is of particular advantage when used in the middle ear. This compound should also be of value in other fields in surgery, as for example in the treatment of infected wounds, or wherever a free discharge is required, the proportion of the antinosine to the nosophen being increased or diminished as indicated. The proportions of antinosine which I have employed are five, ten, twenty and fifty per cent., and the resulting compounds might be briefly named respectively as follows: N-An 5 per cent.; N-An 10 per cent.; N-An 20 per cent., and N-An 50 per cent. It will, of course, be understood that with the increase of antinosine the freer will be the discharge produced, while with its reduction the drying properties of the compound will be proportionately intensified. It must furthermore be remembered that before the application of nosophen, or any of its triturations, the wound should always be cleaned of pus and all debris as thoroughly as possible. The application of nosophen to an open wound does not induce the formation of granulations, but the reverse is true of its more stimulating sodium salt antinosine, and, as might be readily inferred from the preceding statements, the power of antinosine to stimulate granulations is proportionate to the strength of trituration employed. Dr. L. Blake Baldwin has, in his wards at the Cook County Hospital, submitted to careful tests the several strengths of the N-AN trituration, and his experience therewith coincides with the claims herein outlined.

A one per cent. aqueous solution of antinosine may be used as a spray in preparing the nose for operative procedures, though the patient should be forewarned or it may be thought that a nosebleed has been produced. Aqueous nasal douches or sprays should contain about 58 grains of salines to the pint, thus equalling in specific gravity the nasal serum,

and are thus better tolerated by the nose than are solutions of either less or greater specific gravity. This matter I experimented with several years ago, and at the time gave the results of my investigations in a paper entitled "Solutions Dobell."[1] Antinosine, being a sodium salt, is of course, thoroughly compatible with the sodium salts used in the Dobell solution, hence my custom is to add the one per cent. of antinosine to my modified Dobell solution in which the salines are reduced to the amount above mentioned, and the phenol entirely omitted. This solution is clearer than is the simple aqueous solution, and is likewise more permanent, probably in part due to the glycerine contained in the Dobell solution, which approximates five per cent.

Antinosine ten per cent. in glycerine makes an admirable application with which to cleanse and massage the wound in the after treatment following any intra-nasal cutting operation. The patient will frequently note an increased patulency of the nostril after such treatment. This mixture is also of value in the practice of massage upon the atrophied turbinal in atrophic rhinitis. I furthermore use this mixture as an application in the after treatment of the wound following a tonsillectomy by "electro cautery dissection."[2]

Antinosine may be used as a gargle in either acute or chronic pharyngitis in a strength of solution from 1-1000 to 1-55. In ulcerations of the pharynx (which are generally specific) the ulcers are lightly massaged with the N-An 20 per cent. powder and this is followed with a two per cent. gargle of antinosine. In the treatment of ulcers of the nasal septum, my method is to apply the N-An 50 per cent. powder upon dry cotton, when wrapped upon an applicator, and with this to thoroughly massage the ulcer, repeating daily. In empyema of the antrum a warmed antinosine douche, in strength of from 1-1500 to 1-1000, will prove of value and can wisely be followed by the insufflation of the N-AN 10 per cent. powder used sparingly. In acute coryza, nosophen, in combination with a small per cent. of soda and borax, has been highly recommended by Thieson[3] as a valuable snuff. In diphtheria nosophen and its alkaline salt have also been found of value.

In the treatment of chronic suppurative otitis media, we derive the greatest benefit from nosophen and its alkaline salt. An outline of the routine treatment is as follows: After inflation, a warmed one-half of one per cent. douche of antinosine is used as an antiseptic detergent. If preferred, a stronger solution of two or three per cent. may be used by instillation or with the cotton applicator. Whatever method is employed, it is essential that the ear shall be thoroughly cleansed of pus. In some cases, wherein the perforation is not too small, this may be better accomplished by the instillation of hydrozone. If the trouble lies principally in the attic, or if the perforation is small, the thorough removal of the secretions, particularly in the more chronic cases, will be facilitated by

the gentle use of Bishop's aspirator. If there are granulations present, a solution of suprarenal capsules should be first instilled, which will cause shrinkage of the granulations, and thereby afford freer entrance for any fluid remedy which is to follow. After all fluid medication required is completed, the ear is to be thoroughly dried. In chronic cases my custom is to next force inwardly, through the external canal, a ten per cent. nebula of formaldehyde by means of a hand nebulizer,[4] using from 8 to 15 pounds air pressure. In this way the nebula passes through the middle ear and Eustachian tube to the mouth, so the patient both feels and tastes the same. Thus, in addition to asepticizing the tympanum, secretions are often driven out of the Eustachian tube so that the patient is compelled to expectorate. I next lightly insufflate with the N-AN 5 per cent. powder. If there is a pronounced odor observable, the N-AN 10 per cent. strength is to be preferred. Being an extremely light powder, it insufflates easily. Nosophen does not excite the growth of granulation tissue which is sometimes stimulated by iodoform.

For insufflation in office practice, I use the Davidson No. 195 powder blower attached to an "instant" cut-off, and operated with compressed air, controlled by a compound regulative valve with meter, as I find it essential to have a means of exactly knowing and regulating the air-pressure.[5] For this purpose two or three pounds pressure is sufficient. I have found this powder blower to be materially improved by having made in the inlet pipe a very small hole, about one inch below the neck of the bottle. In order to throw the powder through the perforation in the drum-head, as is sometimes desirable in chronic cases, I employ a very slender, long, removable extension piece, which is attached to the powder blower, and under illumination is directed through the ear speculum up to the perforation. Lastly, I loosely pack the external canal with nosophen gauze cut in very narrow strips, which can, if desired, be resterilized before use by heat up to any degree not exceeding 428 degrees F.

Nosophen gauze is of value for packing the nose anteriorly in case of epistaxis, and can, if required, be left in situ so long as two or three days without becoming septic. Nosophen gauze is also invaluable as a dressing after any intra-nasal operation when there is danger of the formation of a synechia. In such case, I cut a strip of a gauze about one inch in width and six inches in length, and introduce it with the introducer here shown:

This instrument tapers in both directions towards its point, and hence can be easily withdrawn, leaving a double thickness of gauze evenly placed between the opposing surfaces. I have left such a dressing un-

disturbed for so long a time as a week or ten days without unfavorable manifestations, though, when the patient is available, it had better be renewed every second or third day.

Columbus Memorial Building.

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A POINT OF VIEW IN THERAPEUTICS.

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Therapeutics is the department of medicine in which empiricism has enjoyed fullest sway—the department in which exact methods have least pertained. It was the primary department, preceding all others, as medicines were given long ages before the nature of the simplest diseases was understood. Anatomy, physiology, chemistry, history of diseases, diagnosis and pathology, including bacteriology, being later developments—succeeding branches of the parent stem. It is the department in which the unskilled in and out of the profession have ever felt most at home. However little the old woman, the herb doctor, the medicine man might know or profess to know about the nature or the history of disease, they have always been ready with, prolific of, remedies. Listen to the conversation of neighbors gathered at the home of sickness. Each has one or several remedies warranted to relieve the condition present. Take the unskilled congregated in some of our cheaper medical monthlies, in the medical Shorts, the medical Universes and others that are distributed around so lavishly, and what do we find? No history of disease, no pathology, no diagnosis worthy the name, but boasted cures of diseases by drugs or else wails for cures. They believe that all diseases ought to be cured if they can but select the proper remedy from our list; if they can but find out what some other man has relieved his patients with. If they cure a patient; I mean, of course, if a patient recovers under their care, they rush into print to tell their brethren of the Short or of the Universe that they can trustingly recommend the remedy in like cases. So much is their attention absorbed by the search for cures that they have no room left for the study of diseased conditions, nor for the refinements of diagnosis. As we ascend the scale of medical periodicals—congregations of medical minds—we note an increasing amount of attention and space devoted to the history of diseases, to records of cases, to diagnosis, to

pathology, to statistics, to original investigations. Take a shining light from among the contributors to the Universe or the Short on one hand; take a Broadbent, a Janeway or an Osler from among a higher professional class. Which representative, think you, will be greater drug given? Which representative will devote more time to the examination and diagnosis of a given patient? This phenomenon is significant. It means something. It is not mere accident.

During the last hundred years or more, advances have been made in all the departments of medicine—through the rise of experiment, through the demand for greater exactness and accuracy of observation by control experiment, through the substitution of demonstration for mere authority and tradition, through the introduction of scientific methods into the chemical, the physiological, biological and bacteriological laboratories, through the advent of the microscope into medicine.

Medicine owes a vast debt to general science. We owe a great deal to workers in chemical and physiological and bacteriological laboratories for methods that have led gradually to important tangible results; to valuable discoveries; workers that have been more scientists than physicians, often not physicians at all, as in the case of Pasteur. Non-medical workers taught us the beginnings, showed us the way in our knowledge of germ life that is revolutionizing medicine. I do not believe that the importance, the influence for progress, for advancement of these mere methods of science can be overestimated. Not only do they tend directly to establish facts, to establish truth, but they necessarily have an influence on medical character. That individual, or collection of individuals whose life or lives are devoted to a search for truth by elimination of all the error possible, must reflect in their characters something of this eternal struggle for truth. Go into any laboratory worthy the name; you find every worker imbued with the spirit of truth; with the spirit that observations must be confirmed by control experiment; that all elements of doubt must be eliminated so far as in their power lies; imbued with the idea that truth must be sought for truth's sake, irrespective of any consequences for weal or for woe that may follow to them personally. As one of them expressed it, when taunted with the suggestion that no practical results would follow his work after he had spent years of labor, "I cannot help whether anything positive comes of it or not. I love the work; it may at least show possibilities that others later may develop." To my mind the hundreds of devoted toilers in laboratories striving for facts, and facts only—for truth—without adequate compensation—with the full knowledge that others will profit by their work more than they themselves, is one of the most inspiring, as it is one of the most hopeful, things in modern medicine. All these exact methods we owe to general science, and so great is the debt of our profession to science that physicians ought, of all men, to be always and on all questions alligned on the

side of science, especially as science holds to a working hypothesis only so long as it is not proved to be an erroneous induction.

Parenthetically we may note here the fatal weakness of homeopathy. The homeopath can never be a true scientist. He starts out with a theory, with a preconception upon which his whole system is built. He must go through life defending it, for once he lets go or seeks for truth, for facts, regardless of his similia, he ceases at once to be a homeopath. He is debarred from progress by the very nature of his case, and this, to my mind, is the explanation that homeopathy has never contributed a single discovery in scientific medicine during the eighty odd years since Hanneman advanced his preconception.

The rise of experiment and of control observation has added a great deal to our knowledge of the natural history of disease. It took long ages for medical men to stop giving drugs—to leave the lancet in its case—long enough to observe the natural course and termination of diseases uninfluenced by drugs. In fact, it is altogether probable that pressure from the outside was necessary before consent was gotten to leave off the accepted treatments. We may easily imagine that it took courage of a high order, at a time when authority and tradition held such sway, for a physician to neglect the measures his preceptor and predecessor had taught him were essential. If observations on the course of the different diseases, uninfluenced by the bolus and the repeated bleedings, had been made at Grey's or St. Bartholomew's, in London, and at the Hotel Dien, in Paris, it is scarcely supposable that the methods of treatment then in vogue would have continued so long. Neither would patients have been deprived of water in fevers and all the eruptive diseases during the generations medical men were afflicted with hydrophobia. The methods of science did not prevail, and mankind paid the penalty incident to the methods of tradition and preconception.

And while we recognize the absurdities and vagaries of homeopathy, we should not forget that it has served a great purpose in forcing on the profession the acknowledgment that much unnecessary medicine, many unnecessary bleedings were injuring patients. And let us not forget that it had to be forced unwillingly and slowly on our profession.

We have discarded the systems and theories of older medicine. We have made great advances in diagnosis, in physiology, in chemistry, in pathology, in bacteriology. Has the advance in therapeutics been commensurate with that in the other departments? Do we still give too many drugs? Every man of middle life recognizes that the men who preceded him gave too much medicine—gave remedies that he has discarded, or gave them in conditions in which he thinks they are clearly contra-indicated. By analogy he must recognize that others to follow him will prune his list.

Take a standard work on therapeutics of fifty years ago. Will he fol-

low it? and why? Or let him take any accepted text-books of today on therapeutics. If he turn to the vast majority of diseased conditions, he finds a long list of remedies recommended. This long list, with the oft-recurring phrase, "May be given," merely means that none are to be depended on, elsewise the effectual remedy would be singled out and the others not mentioned. As an illustration, let us take diphtheria, the treatment of which has been revolutionized by modern methods. How many remedies were recommended in the text-books only six years ago? If he turn to the few diseases for which specific remedies have been found, this long list is also lacking.

I think you will agree that the concensus of opinion of the best observers, as regards tuberculosis, is that life in the open air, diet, hygiene are the measures to be depended on for recovery, and early recognition most important; that reliance is not to be placed on drugs. How many have been the drugs all of us have employed in the endeavor to combat this disease? As we know more of neurasthemia, do we give more drugs, or do we depend on management, on rest, on diet, on hydrotherapy, on suggestion? So in pneumonia, in the eruptive diseases, in nervous diseases, in all the diseases for which specifics or approaches to specifics have not been found, we have to note that our best men give less and less drugs.

Let each member here present review his professional career, and he will find the whole path strewn with drugs tried and cast aside. I take it that the errors of commission will far outbalance the errors of omission so far as therapeutics is concerned with all of us.

What is the significance of the advertisements, publications, endorsements, samples that continually flood our desks? It means that these remedies are prescribed by a sufficient number of physicians to make them profitable. It means that results with previous drugs have been unsatisfactory, and that in desperation for something that will cure, promises, straws are caught at. It means that any approach to scientific method has not been adopted by the mass of us in the profession, and that manufacturers clearly recognize it—recognize that if they make the claims sufficiently strong, oftener preposterous, men will be found to prescribe the remedy and endorse it for publication in the reading matter of our medical journals; recognize that, like the patent medicine men, they must keep their wares before the profession, and that so soon as they cease advertising these fall out.

Institutions, such as hospitals, penitentiaries, armies, should be, it seems to me, our principal hope and reliance in the further elevation of therapeutics toward scientific levels. In institutions the scientific spirit is more apt to pertain. Diagnoses are more apt to be correct, records are more thoroughly made, and made by another than the physician prescribing the remedy. There is supervision and criticism by competent observers, and, lastly, control observations can more readily be made. This leads to statistics which must and does constitute our court of

appeal. The value of any statistics depends largely on the training and standing of the men who furnish them and upon whose record they are based. The statistics of the better institutions will always be more valuable than those of the private practitioner. With the average private practitioner the study of the effect of drugs is largely incidental, his principal object being to obtain the recovery of his patient. The public demands drugs, and as a consequence, our private practitioner is in danger of contracting the drug giving habit. He is called to do something, and too often is he tempted to give drugs before he has made any adequate investigation.

The records of the private practitioner are not fully kept as a rule, nor his opportunity for collecting an adequate series of cases sufficiently great. Bias, too, is more apt to enter into his deductions. All of us must recognize that we can much more readily see the futility or the harmfulness of a drug given by another physician than when given by ourselves. We instinctively, we unconsciously seek to defend what we ourselves have done. It requires a very high order of mental honesty to recognize in any adequate degree our own shortcomings or the consequences of them.

Patients and patients' friends may tend to influence observations and deductions. Let us take a practitioner of the last century. When a patient with pneumonia, or puerperal septicæmia, or smallpox recovered in spite of the repeated bleedings, it was but natural that the fortunate physician should accept the verdict of patient and patients' friends and attribute the recovery to his skill. That bleeding on such a night caused the tide to turn towards recovery! Or let us take our practitioner of more recent years. When children with summer diarrhœas recovered in spite of opium and astringents and improper food, the credit was assumed for the treatment. The same occurred when children recovered from pneumonia and bronchitis, in spite of the cough syrup, the ammonia mixtures and like abominations that were poured into their little stomachs.

I would not assert that we have not derived some good things from private practitioners, nor that we may not do so occasionally in future, but I hold that we should clearly recognize that we are leaning on frail supports and that we should be careful in accepting conclusions. More exact methods will but confirm the therapeutic position of all the drugs that are of real worth—that are really curative as well as the drugs that are useful in alleviating symptoms. And this will not lead to therapeutic nihilism—only to positivism.

The discarding of needless drug giving reacts favorably in two ways. It saves the patient and it tends to make the physician more thorough, for the man who thinks he can cure dyspepsia and diarrhœa with artificial digestants, or with drugs, will lay less stress, less thought on the great problem of dietetics. The man who believes he can cure typhoid fever

with proprietary tablets given at prescribed intervals of so many minutes, will lay less stress on hydrotherapy and management. Contrariwise, he who believes that he can do little for tuberculosis with medicine, will turn his attention to physical diagnosis so that his patient may sooner derive all the benefit possible from fresh air and diet and hygiene. He who recognizes that the eruptive fevers run their course, irrespective of treatment, will not fill his patient's stomach with nauseous drugs.

The churches tell us that a prerequisite of reformation is the conviction of sin, the conviction of error. This is but the expression of the universal law, for so long as men are satisfied with what they are or what they are doing or thinking, they do not seek for change. The sooner we recognize as a profession that we are therapeutical sinners, the sooner reformation will extend.

Only general principles can be dealt with in a paper of this kind. Particulars would require a treatise by a master. Let us remember that the future is pregnant with hope; that as discovery and investigation extend our knowledge of disease and curtail drug giving, the promise of exacter therapeutics brightens. Then, too, the work already done on diphtheria, on tuberculosis, on tetanus, on bubonic plague, on typhoid fever, on pneumonia, on septicæmia, while it gives us nothing positive as to treatment except in the case of diphtheria, does justify the brightest hopes for the morrow.

THE POTHOGENESIS OF MALARIA AND SOME REMARKS ON ITS MANIFESTATION.

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1913 SIXTH AVENUE, BIRMINGHAM, ALA.

To render in this paper a scientific exposition of the pathogenesis of malaria would be an effort that would be unnecessary and incomplete. Any late treatise on the subject of malaria will give you all that is scientifically known of it. As a subject of common interest in all that part of the civilized world where it is known to exist, it has been recognized and studied exhaustively, and, since the conclusions of Laverans were made public, interested scientists have had an intelligent basis for investigation which they have pursued in a way that has been crowned largely with success, and has added much valuable information to our knowledge of the disease. Therefore, to give you a lot of scientific fact and data, and I would have to plagiarize and quote from a source that is accessible to you all. Any late scientific literature published on the subject will give you all that is known morphologically and pathologically of the disease. Hence we will waive all preface and come at once to a discussion of the subject from a logical standpoint, based upon experience advanced practically and devoid of phraseology.

Laveran, a French army surgeon, discovered the malarial parasite in Algeria in 1879, or at least he demonstrated it to the satisfaction of all

interested observers. It has been recently demonstrated that recurrent attacks of malaria are coincident with the formation of the spores of a renewed crop of the parasites of Laverans. The number, activity and age of the parasites all modify the attack, etc., a fact which clears up a confusing point, is, that the character and periodicity of the disease is influenced by successive groups of parasites which arrive at the age of manifestation on successive days, the morphological and biological characteristics of the parasites show that they are of several varieties of a common stock, each capable of influencing the character and time of a special manifestation. In the violent infections of malaria in the Mississippi valley, it has been known for years that in the hemorrhagic form of the disease, the red blood cells were split up, disrupted and discharged through the kidneys as a hemorrhage, but the agent by which the blood was destroyed was not recognized as the malarial parasite, until Laverans made public his findings on the subject, nor was its mode of action understood. The early intermittent fevers of the Mississippi valley do not change in character, as has been presumed, as the season advances, but the blood and tissues being in a proper condition the more serious pernicious form or æstivo-autumnal fever occurs and is recognized as a distinctly different disease from the simple intermittent by the difference in manifestation and the difference in form and shape of the germs. Hence the thought that the simple form can merge into the serious later form is practically a fact, but scientifically incorrect. The onslaught of the simple germ of intermittent fever leaves the blood in a favorable condition to become the medium for the development of the more serious form of the disease. The life history of these parasites are not fully demonstrated, though much of them is known; enough, to my mind, to make me conclude and assert that on a proper examination of the blood, which will show the parasites, the antidote ought to be used, and prevent the manifestation which will surely follow the growth of the germs in the blood. By such course can we obtain certain prevention of malarial fever, As it is more widely prevalent that any other disease in the South, it, of course, stands pre-eminently the one that we should direct our efforts toward preventing, and its elimination ought to be accomplished.

The study of the parasite still goes on, and as there is much difference of opinion expressed by the observers as to the independence of the various forms seen and isolated, yet it is still so unsettled that any student who has had much experience with malaria would be justified in hazarding an opinion on the subject. My own conclusions, after years of enthusiastic observation, is that it is practically one germ capable of changing form, thereby showing an inter-dependence and character as existing conditions change. The beginning of simple fevers early in the season are generated by a young and mild-typed lot of germs, and as the season advances and the conditions for growth of successive generations of the parasite occurs and with the general deterioration of blood and

tissues already impregnated with the mild-typed germ, the type changes in form and character, developing into a strong, active virilegerm capable of attacking and destroying the red blood cells and causing the fatal malarial haematuria that is much to be dreaded. So generally distributed is the germ that we have its manifestation in nearly every section of the United States, though its character is so modified by climate and conditions for propagating that its manifestation is not even here in Birmingham recognized often as a sole and entire factor in the production of a disease. We have it here, very generally and usually associated with our fevers, all of which we find is more amenable to treatment when we combine quinin with our prescribed course, which method of treatment would be unnecessary if we had no malaria present as a contributing factor in the production of our fevers.

I have never seen a geographical division of malarial centers attempted, yet if you will draw a circle, taking in Central America and the countries around the Carribean, and including the southern halves of the Gulf States, you will have therein the zone of pernicious malaria. A circle that will include all territory south of the Potomac river and extending around the central circle will give you the zone of the remittent type of simple malaria. A zone then drawn, which will include the balance of the United States and a like distance in South America will give the zone of the simple intermittent types. In the eastern hemisphere we may take the Mediterraneon sea region as a center and draw same kind of circles and form comparative conclusions showing the general distribution of the disease over the torrid and nearest half of each temperate zone and its annual prevalence in all the world in those prescribed regions. In certain localities within these zones where a high altitude prevails, then these types may be modified or absent. Take the high mountain regions of North Carolina, Tennessee, Virginia and Kentucky. Any form of malaria there is very infrequent, or almost unknown; yet further north, say around Washington, D. C., in the Ohio valley, in Illinois, Indiana and Ohio, we sometimes find a very serious remittent type of fever. At a latitude further north even than the other, yet at a lower altitude, which, I think explains the cause for the condition in those localities.

An important pathological condition present in this disease are the changes which occur in the blood-making organs and the liver. I do not think that the nomenclature of the different species of germ causative of the various forms of malaria at all settled. The names so far suggested and used not applying scientifically to the subject. However, we know that here in the South the germ of the algid or congestive form of the fever, and those influencing the hemorrhagic type, both of which are pernicious, should be named, classified and described for general recognition and annihilation. The simple form is not so serious, except so far as it is an intensifying factor in the progress of other diseases.

I would suggest a course of reasoning deduced from practice that all the forms are due to a polymorphous agent. Time, season, numbers, po-

tency, location and pabulum all combine in various degrees to make the impress of the type, which may be recognized and diagnosed accordingly.

All attempts to cultivate the germ outside the body have been unsatisfactory, though in nature's laboratory, in the alluvial lands, along the streams of the South they are evidently bred and distributed in a very widespread way. In my own person, after living several years in the Mississippi swamps, I came to Birmingham five years ago thoroughly impressed with the parasites. They would multiply with sufficient force and number to cause a manifestation or a paroxysm every twenty-one days. I would have fever, go to bed for from one to three days, use a purgative and febrifuge and follow for two days with quinine; would recover, and the spell would recur at the next regular day. That condition remained present for two years, 1896-7. In 1898 my periods of recurrence began to occur about every six weeks. Time and intensity progressively diminished, until the spring of 1899, when I had the last attack, which confined me to bed. Since then, or for more than a year, I have not had a manifestation sufficient to call for a course of treatment.

Numerous friends during the past year have remarked upon the change in my appearance, from the sallow, bloated, anæmic hue of that period of malarial poisoning, to the present glow of red color on my skin, which is indicative of the normal condition of the red blood cells, which used to be destroyed by the malarial parasites.

I continue to refer to the germ as a parasite, because I cannot bring myself to the point of recognizing any of the various names advanced by the numerous Italian, French, German, American and Spanish observers. They lack unanimity, and are nearly all unscientific and misleading, each one seeming to want to perpetuate himself in the name of the germ. A real generic name has not yet been advanced. The one who determines a real practical plan for the general annihilation of the parasite will be the man who deserves all praise and a lasting renown, regardless of whether the germ is properly named or not.

Let me emphasize the importance of an examination of the blood for the Laveran parasite. In any case where there is a suspicion of malarial poison, a good practical way is to obtain a drop of the blood to be examined, drawn from a small puncture made on the arm; put it on a slide and cover and examine at once. If the examination cannot be made at once, then the specimen will have to be stained. A most excellent agent for the purpose is Loeffler's methylene blue, prepared according to any of several good formulas. When the presence of the parasite is determined, you may then prescribe for the condition, and continue the treatment until the microscope ceases to reveal the presence of the germ. Then a tonic course to restore relation between blood and tissue and promote a resumption of normal function in the impaired centers will soon remove effect, and your patient is discharged thoroughly cured. ere the disease had become potent enough to manifest usual characteristics.

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It is useful in sub-acute gastritis, gastralgia, pyrosis and allied stomachic diseases, irritation of the intestinal and urethral mucus membranes, Diarrhœa, Dysentery, Leucorrhœa, Gonorrhœa, etc. It is suggested to use egg albumen mixed with Bismuth Cream for injection in catarrhal conditions.

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Selected Articles.

APPENDICITIS FROM A MEDICAL STANDPOINT.*

By I. N. Love, M.D.,

ST. LOUIS.

Every appendix vermiformis, healthy or diseased, is individual unto itself. As its anatomy varies, so also does its pathology. McBurney's point is not always the proper point at which to look for the appendix. It may deviate to the left, up or down; in fact, it has been found in almost every region of the abdomen, and I once saw a man who, after long illness, passed fecal matter mingled with the urine from his bladder, was operated upon for supposed prostatic abscess and recto-urethral fistula without avail. A supra-pubic operation revealed a previous appendicial abscess; the appendix being resting upon the bladder, adhesions occurred, ulceration into the bladder followed. None but the experienced would have dreamed of looking here for an appendicitis.

Indeed we must remember that the various parts of the human anatomy vary as widely as do individuals, viewed from any standpoint. The primary necessity for a case of appendicitis is to have a physician in charge who can make a prompt diagnosis. It may be said that this is the case in all forms of disease, but it is more so for the successful management of appendicitis than for almost any other lesion.

Let us all remember that every case of belly ache, cramps or pain in the guts presenting itself is a possible appendicitis; that any history of a previous typhoid fever, inflammation and congestion of the bowels or ovaries and peritonitis is a possibly unrecognized appendicitis, and that every victim of indigestion, particularly intestinal, is on the verge of appendicial inflammation, particularly if he eats to excess or goes on a debauch. Let us keep in mind, too, that the victim of la grippe, the uric acid diathesis, and he who worships at the shrine of the three L's"—Laziness, Luxury and Lust—is prone to the disease under consideration as well as the athlete. Appendicitis has been classified as catarrhal, ulcerative and perforative; but it is well to realize that an attack of appendicitis is inflammation of the appendix, and it is impossible to draw the sharp lines of distinction.

We doctors must learn and we must teach the fact to the laity, that an attack of indigestion, cholera morbus, diarrhœa, accompanied by pain in the belly, intestinal cramps, etc., must be treated intelligently along the lines of helping nature to get rid of offending material, recognizing pain always as nature's signal that something is wrong, and

*Read to Chicago Meeting of the Mississippi Valley Med. Association.

that it is our duty not to cover up and mask the sign, but to coax and coddle it by simple means, securing its help in locating its cause.

I do not hesitate to say that the doctor who would administer sedatives and pain killers to a case before making an approximate diagnosis, even though it demanded an all-night visit, would be justified in doping and deserting a woman in labor, without making an examination necessary to determine the position of the child or the stage of the labor, with a view to obtain his own quota of sleep. The class of cases to which I have referred are mistreated unless the attendant secures a thorough clearing out of the bowels (at least of the colon and stomach) before applying remedies which check peristalsis, and this can be best and most easily accomplished by means of hot water used freely internally, from both directions, and externally in the form of a hot all-over bath or the hot wet pack. The stomach may be well washed out by the drinking of one or two pints of hot water (or the stomach tube); as water is ejected and the washing is complete, another pint or two may be introduced; and quiet upon the part of the patient, with the head low, ice cloth to mouth, mustard plaster over "pit of stomach," will result in the water's retention; stomachic tranquillization will follow, and pyloric relaxation will soon convey the water into the bowel. If now repeated large, high-up enemas (and no syringe is complete without a long rectal tube) be given of one-half gallon—usually more—of hot water, freely mixed with soap (temperature of water to be 110 degrees F.), there will be a pronounced peristaltic wave all down the line, and irritating matters, undigested food, ptomaines, etc., will be carried freely out, and whether we have a case of appendicial trouble, beginning typhoid fever, or what not, our patient is in better shape. A colon and ileum loaded with fecal matter are a good riddance, no matter what we have before us. Lavage of the colon, free flushing, will start the current from the stomach downward,

As evidencing the value of colon lavage, Bidder, Schmidt, Zolesky, Rosenberg, Krull, Lowenthal, Barlura and others have reported clinically that the flow of bile, the urea, and indeed all the secretions are greatly increased. The eminent and painstaking specialist in gastro-intestinal disease, Dr. Fenton B. Turck, of Chicago, after numerous careful experiments and laborious effort in the treatment of the abdominal viscera in a large number of patients through the colon, has proven that the high-up introduction of water of a temperature of 111 degrees F. (owing probably to the favorable arrangement of the nervous mechanism and the reflexes of the colon) into the colon increases the blood pressure, the kidneys are stimulated (elimination of urea almost uniformly doubled), hepatic function increased, greatly increased leucocytosis induced, all the effects resulting in a general accelerated metabolism, oxidation and elimination; in short, the result is general cell activity.

Surely an all-night seance, if need be, with the acutely ill, resulting in a clearing away of fermenting food, accumulated fecal matter, ptomaines, etc., etc., whether he be in the initiatory stage of severe appendicitis, typhoid fever, scarlet fevor or it matters not what, places our patient in a position more favorable to a mild course and prompt recovery.

I feel that I am justified in claiming the uniformly favorable termination of my intestinal cases for several years back to the fact of having given them the benefit of complete, prompt intestinal evacuation by the means of repeated colon lavage. I have found it well in some of my cases to administer broken doses of calomen triturates (1-8 grain) every hour (washed down by a glass of hot water) for ten or twelve hours, followed by a half tumbler full of Apenta water (a most excellent saline cathartic); this in conjunction with the colon lavage.

We must not take the word of the victim or his attendants regarding the evacuation of the bowels or anything else pertaining to the case until we have corroborated the evidence by all our five senses. After our diagnosis is made, at least approximately (and I claim that we or our assistant should remain with our patient until this is done), we may be safe in giving some potent pain reliever, if the suffering demand it; but opium in no form should be administered (the same as in administering chloroform or ether) until radical interrogation of the kidneys and general idiosyncrasy establishes the fact of its safety; but it should not be given at all unless we are absolutely sure that we are safe in ruling appendicitis out of our calculations.

Three deaths definitely, and possibly more (observed within a year), of uræmia, superinduced by morphine in cases of acute indigestion, complicated with crippled kidneys, which were not previously suspected, emphasize, in my mind, the point made above. Had the hastily summoned physicians met the emergency properly, they would have made their call an all-night investigation, instead of a hasty and reckless use of the mephistophelean morphine in the hypodermic syringe. At this point let me urge, with all the emphasis at my command, that the hypodermic syringe is mightier than the sword in the hands of the ignorant, the lazy, the thoughtless or the backboneless doctor.

After the alimentary canal has been entirely emptied (and not till then) we can thoroughly investigate it, and the complete intelligence and acute sensibility of the patient is essential to this investigation. On general principles I will say that it is very exceptional when a victim of abdominal disease, medical or surgical, is not better either before diagnosis or after, without opium than with it.

Let it not be forgotten that the pain of an appendicitis may be anywhere in the belly, and it is often least marked at the real site of the appendix (at least in the beginning). We all know how hard it is to

locate definitely the intense pain of an ulcerating tooth, and we must keep in mind the scattered reflexes of the abdominal cavity. In a general way the reflected pain is apt to appear near the navel or in the vicinity of the stomach, and not above the diaphragm, as it is in gall bladder and bile duct disturbances; not to the end of the pelvis or to the thigh, as in irritation of the urinary bladder, though sometimes (as stated by Morris) the pelvic ganglia are excited to the point of radical appendicitis reflexes along the lines that are disturbed by a stone in the bladder. Palpation with the fingers of both hands, the one inside and the other outside of the abdomen, is the only method for obtaining evidence in a case.

Robert T. Morris, high authority in America on appendicitis, relates in some of his literature the remark of one of his fellow students in college days, who was instructed to examine the uterus in the dispensary. Says Morris:

"My companion introduced his finger into the vagina, and, after poking about for awhile, informed the instructor that the uterus felt just like the middle ounce of mush in a pailful of mush. I have little doubt that today this man can make out not only the different parts of the uterus on palpation, but also the ovaries and oviducts, and perhaps the ureters if he has taught his finger tips with as much care as he would employ in teaching a setter pup to retrieve birds."

I have been amazed almost uniformly, when called to cases under the care of other medical attendants, to find that they have not made a thorough investigation by first emptying the colon and then palpating the abdomen with one hand, with the forefinger of the other introduced up through the rectum. Here let me urge a more liberal education of the sense of touch upon the part of the doctor. (It took me ten years to unlearn the excessive importance of the fever thermometer. It is valuable often, but the pulse is a hundredfold more so, whether the lesion be abdominal, pulmonary, cerebral or cardiac, and I fear the clinical thermometer has been largely responsible for the absence of pulse knowledge in our profession during the last two or three decades). Yes, let us cultivate the "tactus eruditus" which will enable us to almost close our eyes and make a good diagnosis. We may take points from those especially skilled diagnosticians in our profession who have made the affliction of blindness intensify their sense of touch and hearing to such a degree as to develop them almost up to the point of being wizards of diagnostic wisdom. The eminent Dr. Babcock, of the fair city of Chicago, is a shining illustration of this thought.

I have studied the question under discussion carefully for many years, but three years ago a loved one of mine fell a victim to appendicitis, and for eighteen months suffered constantly, during which time I almost completely relinquished all work, giving attention to this case.

I very naturally devoted myself to the special study and observation of the subject.

I do not propose in this paper to consider or quote the views of other men (and there has been no line written or thought enunciated that I have not carefully read and weighed), but my own conclusions, and I must say they are not of a character to make me proud of my profession as a whole, viewed from the standpoint of appendicitis. It appalls me to recall the advice freely given to me by men very prominent in our profession against surgical interference, some going so far as to say that they had never had a case operated upon and had never lost a case.

First of all, no doctor's dictum is worth anything regarding the subject unless he has been a persistent student and placed himself in a position to have exhausted the entire literature of the subject and to have seen many hundreds of cases, under his own care as well as others under the care of abdominal experts, viewing them calmly, medically and surgically, without prejudice, keeping always in mind the thought in relation to the victim, "put yourself in his place." Prominent authority has well said, "An immense amount of bad advice is given to appendicitis patients by physicians who are not informed, and who do not know the contents of the text-books of our authorities upon the subject. It is not the fault of physicians, but of society, in demanding of physicians so much information upon so many subjects that it is a physical impossibility for them to cover the ground."

This may be true, but society does not demand that a physician should assume to know things of which, as a matter of fact he is completely ignorant.

God help the family or the patient under the care of a universal specialist who is so busy that he can never go to a medical society and get the benefit of other men's views and experiences, and have the helping effect of criticism—some one to rip him up the back, as it were.

Moving as we do in a narrow groove, going from house to house where our word is law and few dare say nay, we run great risk of becoming dogmatic autocrats, saturated with the idea that we know it all.

I sometimes think it would be fortunate for us and humanity, as well as science, if every medical case had a pair of doctors instead of one. Then, as in legal cases, where there is always two attorneys pitted against each other, each would be stimulated by the other to his best endeavor. Indeed, considering the supernumerary doctors in every community there would be fewer idle ones under such conditions.

Unfortunately for us and our patients, we, as it is, are counsel, judge and jury, and I fear sometimes executioner. I believe a law should be passed that no capital operation should be performed until at least three to five experienced and well equipped doctors shall have passed upon the case (the major number to be established surgeons), and no two of them in the same medical college.

I believe further that every hospital, private as well as public, should be rigidly inspected by legalized competent authority, and that not only should every licentiate to practice medicine be made to pass a proper examination, but that every practicing physician should have to give evidence every five years of his ability to continue in the work.

First of all, I firmly believe that unless a doctor be especially skillful and dexterous in the handling of tools, the knife, the scissors, the needle and thread—a good mechanic, an artist—he ought not to do surgery of any kind. A good surgeon with a deft, delicate hand, had far better graduate from a manual training school, to serve short apprenticeship to a tailor, a carpenter, a sculptor and draughtsman, than to have spent years with the classics and delving into bacteriological lore.

John Hunter, Ephraim McDowell, Marion Sims, Lawson Tait, Joe Price and Robert T. Morris are striking examples of the born surgeon, plus work.

And, by the way, we may well ask if we are not stuffiing too much in our four or five years at medical college, and losing much by relinquishing the old-fashioned apprenticeship of three or four years as understudy under a good preceptor.

If these are the requisites for the general surgeon, they are doubly so for the one who does abdominal work. Except in rare cases, the general physician should not do surgery, and the general surgeon should not do pelvic or abdominal surgery any more than he should do eye surgery.

Of course, in sparsely settled neighborhoods, for a little while to come, in emergencies, the physician should be equipped to do anything and everything; but rapid transit is eliminating distance so fast that all will soon be in reach of the special skill of those in large centers, but, as a matter of fact, there is no reason why the country surgeon, if well endowed for the work, should not, with the numerous post-graduate facilities, equip himself well for every demand. Lawson Tait, the provincial surgeon of England; Ephraim McDowell and Marion Sims, the country surgeons of America, should stand as examples to all rural workers as to their possibilities.

In every community self-interest and humanity demand that the doctors get together and take stock as to their respective capacities, and divide up the work. There is not a section in America today where there is not a liberal supply of physicians, and no one man need be so overcrowded with work as not to do good work. We must all remember that the man in our profession who is in the work only for the money that is in it, is unworthy.

The misfortune is that the numerous wildcat medical colleges of the land, which have inveigled the untutored and ill-prepared from a thousand hills into the ream of medicine, are largely responsible for many evils in our guild.

Unfortunately, there are too many doctors who are surgically ambitious, not that they are specially graceful and well equipped along these lines; but the Bob Sawyer spirit in them prompts a love of the chances for the grand stand appeals to the groundlings, the vulgar herd, who think that the man who can carve and leave his trail in blood is the really great man in the profession. As a matter of fact, we should realize that this same vulgar spirit of the mob prompts it to idolize the brutal victor in a prizefight or enjoy a hanging, and we should, more of us, determine to devote ourselves to the less appreciated, but really more skillful field of diagnosis, therapeutics, physiology and pathology, and leave the realm of surgery to the born mechanic, artist, and give him our earnest co-operation and support. I fear sometimes that the prospect of larger fees allures men into the domain of surgery whose fingers are all thumbs, and who are as awkward in handling the scalpel as "the man with the hoe" would be in wielding the poet's pen or the painter's brush or the sculptor's chisel.

This brings me to the relation of the specialist in internal machine and the surgeon. The relation is surely a delicate one. We should demand of the surgeon, if he expects our support, that he be worthy of it by first of all fitting himself by knowledge and experience gained under master surgeons for the work, and after not less than ten years of general work we should demand absolutely (and it takes ten years to develop a man's special fitness) that he limit himself to surgery. How else can we co-operate?

Surely if he accepts our case of surgery, sent to him as a surgical expert, he should decline our patients who go to him for medical service, allured by the thought that our reference of cases to him announced his general superiority. Any other course is not honest, but hoggish.

Furthermore, I insist that any case under the care of a good physician, a good diagnostician, competent to know when surgical interference is demanded, and just and generous enough to give his patient the benefit of expert manual and mechanical skill, still needs the constant care of his physician along medical lines so that he should remain with the surgeon, if not in attendance upon some infectious disease at the time, the two in conjoint care of him equally responsible, no visit to be made (except in emergencies) by either without the presence of the other. The physician is responsible for the diagnosis, for the selection of the surgeon, for the work as done, and is entitled to exactly the same fee as that of the surgeon, if his reputation be as great, and larger if it be greater.

Indeed, in all cases a physician the same as a surgeon should charge a fee for attendance in harmony with the severity of the case, the responsibility involved, the value of the life, the ability of the patient to pay and commensurate with his own reputation. In such cases the

bills should be rendered synchronously and payments made equally, neither being a preferred creditor. Of course, the question of commission cannot be discussed by honorable men, but the time has long since passed when the surgeon should deem himself the grand Pooh Bah and Generalissimo of the profession. Now, such an one runs the risk very properly of being considered a "Jack of all trades" and good at none.

When doctors and surgeons arrive at a full knowledge of not only how to spell the word reciprocity, but its full meaning and the Golden Rule (As ye would that others should do unto you, do ye even so to them), as well, there will be no more good doctors and a smaller number of poor surgeons and a goodly number of good ones, and the latter will not need to cut rates with each other for surgical operations, and make visits in large numbers in competition with medical men. Keeping in mind our duty to ourselves, to humanity and to God, there need be no trouble regarding the relations of the physician and the surgeon; but I hope I will be understood when I say that I believe the misinterpretation of our code of ethics protects mediocrity, general incompetence and almost criminal ignorance and recklessness in physicians and surgeons.

Doctors in almost every community are passing as surgeons and expert physicians (protected by the mantle of membership in our societies) who are painfully incompetent, and in many cases they are more devoted to the discussion of our code of ethics than they are to science. Unfortunately, nerve, audacity, secret societies, church connections and a love of lucre secure them cases for medication, manipulation and evisceration.

Reckless surgery in incompetent hands has been responsible for much of the aversion of the public to surgical interference in many cases demanding it. Happily for physicians, their work and results from incompetence are not so apparent.

I have taken it for granted that every member of this learned body is familiar with abdominal surgical literature, and those who have made that which is authoritative have written as ideal surgeons, working under proper conditions, and I take it that that is what every man who does surgery should be and can be if he tries; and if he can't then he should abdicate in favor of the man who can.

Considering surgical interference in appendicitis to mean interference by men as capable as Tait, Price, Robert T. Morris, Reed, Baldy, McMurtry, John B. Murphy, Ochsner, John B. Deaver, and such as these, I include that appendicitis, from a medical standpoint, means that the earliest possible diagnosis should be made, and the appendix should at once be removed. Handled medically, the mortality is about 25 per cent., but of the 75 out of the 100 who recover, we can never know how many may have recurring attacks, and how many remain through

life chronic invalids or die of other diseases invited by their unhappy condition.

In the hands of ideal surgeons (the expert abdominal surgeons I mean), the mortality announced (and I have personally observed the truth of the claims made by some of our best men) is from 1 to 3 per cent.; but even say it is 10 or 20, are we not all anxious to save five, ten, or fifteen lives (or even one) out of a hundred? I insist that with the light we now have and the record now made, that if a surgeon makes a poorer showing, there must be something wrong with his methods, and he should, in the name of God and humanity, correct them, and unless he does, he should be amenable to the law.

The surgeon who does not believe in rigid asepsis, as applied to his case, his instruments, his entire paraphernalia and his personality should be eliminated, the same as the physician should be who does not accept in a judicious way modern medical methods in the treatment of diseases, as, for instance, he who, with the evidence before us, denies his victims of diphtheria the benefit of antitoxin.

At this point let me remark that there is either something in sepsis and infection or there is not, and if there is, no man should be permitted to attend surgical cases, or parturient women who give his services to cases of scarlet fever, diphtheria or other forms of real or supposed infectious diseases. With the knowledge we now have, I assert (in all kindness) that the physician or surgeon who attends both infectious and surgical or obstetrical cases is either ignorant or reckless, and in either case is open to charges of malpractice, and since the world is well supplied with doctors, there is no emergency excuse that can be presented in extenuation.

Are we not correct in insisting that those surgeons who work in sacred regions (speaking anatomically) where a single germ may be fatal when elsewhere the general result would be but little affected, shall guard themselves against carrying infection, so limit their work and husband their physical and psychical resources as to be always in such good form that their five senses, the sixth also (common sense), but most of all the seventh (moral sense), shall be acutely alert and their hands shall have their fullest cunning? The victim of excessive fatigue, drink, drugs or disease is in poor form for practicing medicine, but least of all surgery.

The half-sick doctor in charge of a patient is an epitome of the blind leading the blind, and all these points are arguments in favor of every medical and surgical worker limiting his labors, and having a pride as the years pass in not doing more work but better work, and having his patrons say how well you do your work, not how cheap, and realize that there will be one or more months in every year that his services are not available, as he is taking his proper vacation, recreating and seeing how the good workers the world over do their work.

I have seen surgery almost from the time I was sixteen years old, at the hands of masters, too, and I know well, if I know anything, that the happy-go-lucky, devil-may-care, modifiedly maniacal manifestation of Jack the Ripperism operating seemingly for the emotional pleasure, almost suggesting the insanity of Sadism; the knockdown and drag out, the sloppy, unclean type of surgeon, as well as the overworked, fagged-out general family practitioner, and the man who has only limited opportunities for gaining knowledge of the best pathology, technique, and securing proper practice and skill in a general way should be called down and not permitted to invade the abdominal cavity. Too many men read the records made by the masters, then browse around for a week or ten days in some clinical amphitheatre, and fancy themselves full-fledged experts in abdominal work, when, as a matter of fact, they can't interpret the pathologic conditions they may find any more definitely than they can correct them.

In observing the work of Price, Robert T. Morris, Deaver, C. A. L. Reed, McMurty, Ochsner, Murphy, John Young Brown and others of our most successful workers in abdominal surgery, I have noticed that the abdominal incision was usually small (about one inch and one-half), the instruments few, and few or no other hands permitted to touch the field, the material or tools used, and quickness of work was uniform, so that the belly interior was exposed the briefest possible time.

THE DATE OF THE COMING PAN-AMERICAN MEDICAL CONGRESS.

A correspondent of the Philadelphia Medical Journal calls attention to the unseasonable date set for the Pan-American Medical Congress at Havana, and suggests that it ought to be prostponed a full month. The objections to the published date, December 26, must have occurred to every medical man in the United States who has thought of attending. First of all, one is reluctant to leave home at Christmas. This consideration alone will prevent the attendance of men who have no very weighty reason for going to Havana. Next comes the importance of the new year as settling time.

If a doctor were willing to sacrifice his Christmas at home, his business interests would suffer by his absence at New Year. To postpone the congress until January 26 would assure a much larger attendance than can reasonably be expected in Christmas week. It is doubtful if a majority of those who intend to present papers will be on hand at the time proposed, while of those who make of such meetings a small outing a good majority will certainly stay at home.—Maryland Medical Journal.

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in the gastro-enteric disorders of children is an essential procedure. Why not employ a perfectly safe but highly efficient germicidal solution for this purpose? "Borolyptol"

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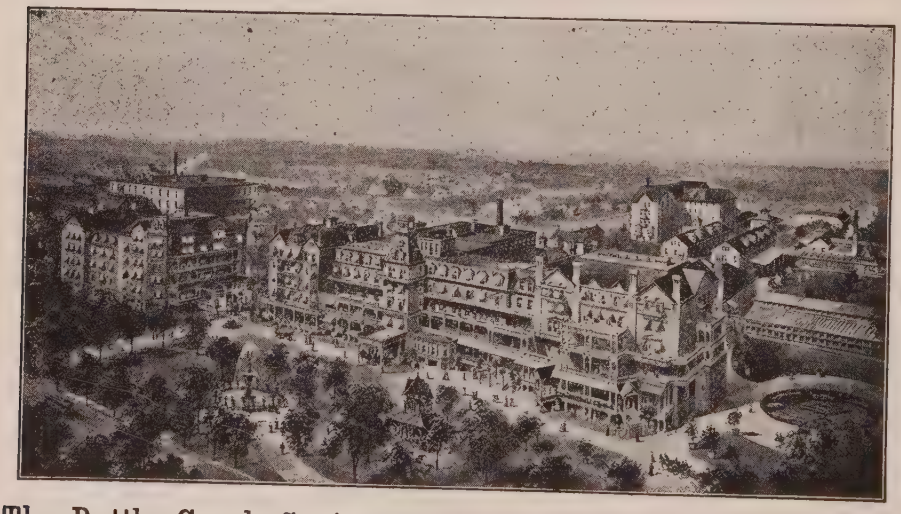

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Is a place where chronic invalids, especially those suffering from the various forms of indigestion, the diseases peculiar to women, constipation, chronic malarial poisoning, anemia, obesity, the uric acid diathesis, neurasthesia, migraine, and similar ailments are trained into health by the aid of systematic regimen, scientific hydrotherapy, massage, Swedish movements, Swedish gymnastics and other rational means. Most cases of Bright's disease, diabetes, locomotor ataxia, and many other maladies which are incurable under ordinary conditions, are greatly improved by the combined use of rational remedies and systematic regimen, and many are practically cured. Extensive bacteriological, chemical and microscopical laboratories connected with the institution afford excellent facilities for accuracy in diagnosis and original research.

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Editorial.

JNO. C. LeGRAND, M. D.,.....Editor and Prop.

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Courtesy.

It may seem rather singular to some that a medical journal should devote space to a discussion of courtesy, or, if you prefer, to politeness; but it is in the province of a medical journal to discuss any and all questions of interest to members of the medical profession; and most assuredly there is nothing in which a physician can invest which costs so little and which brings such large returns as a supply of courtesy which can never be exhausted—a supply which can be drawn upon after one has eaten a mean breakfast, or has been up all night, or when listening to a paper or a discussion during the meeting of a medical society, or in coming in contact with medical men of all degrees of skill.

The Lord has done much for the man who can be uniformly courteous under all conditions. With the average man it is often much easier to be so discourteous as to make an enemy instead of tying closer a friend.

We are all too prone to forget to count the profit and loss of courtesy. We too often feel that certain individuals cut no figure in the affairs of our lives, and it makes no difference whether we salute them when we pass them on the street, whether we give them respectful attention in medical gatherings or whether we extend to them due consideration in

consultations. But we should remember that no man lives to himself; that every man has his influence; that there is an innate principle in the heart of man which leads him to resent a discourtesy, and that it is far better to have the good will even of the most insignificant individual in any community. Indeed it is better to have the good will of every dog whom you pass; for the time even comes when a dog can do you an injury if he dislikes you.

It pays to be courteous to all men, but especially should medical men, under all conditions, be courteous to the members of their own profession. Think along this line, and allow your thoughts to cause you to resolve that you will profit by this gentle reminder as to the desirability and value of an inexhaustible supply of courtesy.

The Carping Critic.

This hot weather may not be a propitious time to discuss the misgivings of the medical profession, but we shall risk a few lines from Dr. Lamphear's editorial notes in the August issue of the American Journal of Surgery and Gynecology:

But, says the carping critic, is not the railway surgeon, albeit he is a college professor and a distinguished member of the American Medical Association, in just the same position as the surgeon to the "50-cent hospital association," which has been so bitterly condemned by medical societies and criticized by medical journals? Precisely! But the profession at large has failed to recognize it—possibly because of the immensity of the one and the littleness of the other. It is a common expression that the man who steals a thousand goes to prison, while he who steals a million goes free. The parallel is an exact one between this and the hospital organizations. The surgeon who organizes a few hundred working girls into a "Woman's Hospital Association" and equips a few rooms as best he may from the perhaps 300 50-cent pieces he receives monthly is made to cease his objectionable practice, close his co-operative hospital, throw the poor girls back upon the tender mercies of a cold world, or at least to become a burden to some over-worked doctor who gets neither thanks nor pay; the "chief surgeon" of a railway employes' association (commonly termed "chief surgeon of the railroad"—which he is not), with 30,000 or 60,000 members, is elected president of the society which condemned the methods of his brother practitioner. The one had a small remnant of the $150 a month received from the members; the other has a "salary" of $6,000 per annum. Verily—consistency, thou art a moss-agate!

"Then," exclaims the doctor who does lodge-work at $1.00 per annum for each member, "I am as guilty as the man who runs an assessment hospital?" Exactly so; and "lodge doctors" and "contract surgeons" have been condemned time and again by societies in every part of the world. Even now, our Canadian brethren are treating lodge-doctors by expulsion because they agree to do the family practice of each member

of the lodge at $3.00 a year—1,000 members, $3,000 income, plus what can be made outside; but no one has heard of even a vote of censure for surgeons working for railroad and other corporations upon an exactly identical contract, save that the assessment per individual is far less than the $3.00 lodge contribution. Across the border also, then, consistency is a jewel of purest ray serene, that to be appreciated hath but to be observed within the halls of medical societies.

But, it may be asked, how can one reconcile the three statements: (1) That "lodge-practice," "contract-practice," "assessment hospitals," "railway surgery" and the like are based upon a purely socialistic or communistic principle; (2) that such contract work is in violation of the Code of Ethics, is reprehensible, is objectionable; and (3) that the twentieth-century physician will be the head of legalized socialism? The answer is easy.

Under our present system of government, the physician is educated at his own expense, lives at his own expense and is buried at the expense of his friends, for he usually fails to accumulate enough to pay for cremation. His very life depends upon the patronage of his neighbors, derived through his competition with other practitioners of the community—a typical struggle for existence and survival of the fittest. It is not right that the one who is not weakest should be compelled to go to the wall by a combination which he can in no way control, but which, by mere force of accident, his hitherto unsuccessful rival may profit by; it is a struggle in which intrigue, and sometimes bribery, or worse, triumphs (temporarily at least) over intelligence and skill and honesty—all that makes for good in our profession. It is not a victory for socialism when such a result occurs—it is the brute force of numbers against ability with the weakness of isolation; unfair competition. In true socialism there is no unfairness and no competition.

It Must Be Erected.

The medical profession in Alabama cannot afford to let fail the effort to erect a monument to the memory of Jerome Cochran. He gave the best part of his life in securing in Alabama the most perfectly organized medical association in the United States. In perfecting such an organization, no one can estimate the mental force which he put forth, and for this labor of love the profession in the State owes a debt to his memory which it can but poorly pay by placing on the capitol grounds at Montgomery a marble monument.

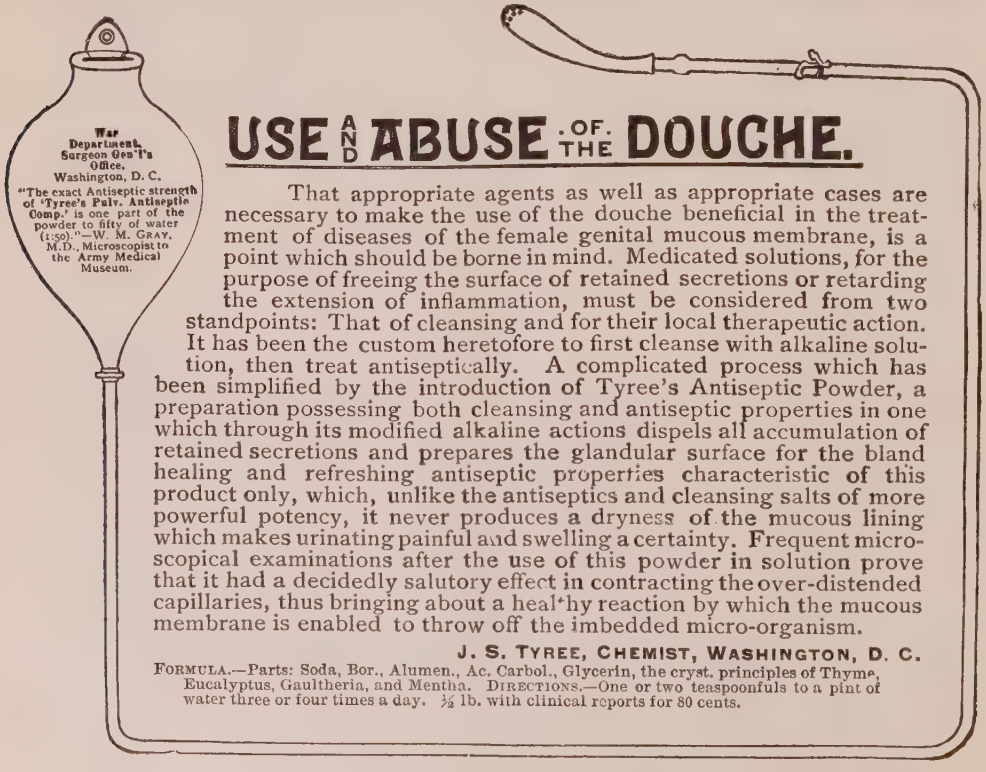
The State Board of Censors at the last meeting of the State Association, in discussing a suggestion contained in the president's message, says: "The president's message closes by a fervid appeal in behalf of a cause that should enlist the genuine sympathy and generous aid of every member of this Association, namely, the erection of a monument to Jerome Cochran. This board avails itself of this opportunity for declaring that its desire to see an appropriate monument erected has

not in the least diminished, and it hopes that every member of this Association warmly participates in this feeling.

"The president's recommendation that $1,000 be appropriated out of the funds of the Association toward the erection of the proposed monument is one the adoption of which would do great credit to this Association, but we find that Article 62 of the constitution seems to forbid any appropriation of the funds of the Association, except such as may look directly to the advancement of medicine. However much we would like to follow the dictates of our hearts in this matter, we feel compelled to obey the Constitution; therefore must decline to approve this recommendation of the president."

This seems to settle the fact that an appropriation cannot be made from the funds of the Association, and that the money must be raised in some other way. We believe the rank and file of the profession in Alabama will willingly contribute to the erection of this monument, and that to raise the money it is only necessary to adopt some systematic plan. Why not prorate the amount needed among the different county societies in the State, and ask that the sum be raised by the next meeting of the Association? Or who will suggest a better plan for raising the money in the next issue of The Journal? Let those who are interested write us and give their suggestions.

The monument must be erected.


War Department,
Surgeon Gen'l's Office,
Washington, D. C.
"The exact Antiseptic strength of 'Tyree's Pulv. Antiseptic Comp.' is one part of the powder to fifty of water (1:50)."—W. M. Gray, M.D., Microscopist to the Army Medical Museum.
USE AND ABUSE OF THE DOUCHE.
That appropriate agents as well as appropriate cases are necessary to make the use of the douche beneficial in the treatment of diseases of the female genital mucous membrane, is a point which should be borne in mind. Medicated solutions, for the purpose of freeing the surface of retained secretions or retarding the extension of inflammation, must be considered from two standpoints: That of cleansing and for their local therapeutic action. It has been the custom heretofore to first cleanse with alkaline solution, then treat antiseptically. A complicated process which has been simplified by the introduction of Tyree's Antiseptic Powder, a preparation possessing both cleansing and antiseptic properties in one which through its modified alkaline actions dispels all accumulation of retained secretions and prepares the glandular surface for the bland healing and refreshing antiseptic properties characteristic of this product only, which, unlike the antiseptics and cleansing salts of more powerful potency, it never produces a dryness of the mucous lining which makes urinating painful and swelling a certainty. Frequent microscopical examinations after the use of this powder in solution prove that it had a decidedly salutory effect in contracting the over-distended capillaries, thus bringing about a healthy reaction by which the mucous membrane is enabled to throw off the imbedded micro-organism.
J. S. TYREE, CHEMIST, WASHINGTON, D. C.
FORMULA.—Parts: Soda, Bor., Alumen., Ac. Carbol., Glycerin, the cryst. principles of Thyme, Eucalyptus, Gaultheria, and Mentha. DIRECTIONS.—One or two teaspoonfuls to a pint of water three or four times a day. ½ lb. with clinical reports for 80 cents.

Miscellaneous Notes.

Dr. W. H. Wilder has returned from Kansas City.

Dr. J. C. Morris spent a few days in North Carolina during the month.

Dr. J. D. Gibson and wife have returned from an extended trip abroad.

We call attention to the Medical College advertisements in this issue of the Journal.

Dr. J. D. S. Davis has been up at St. Clair Springs for two or three weeks.

Dr. J. I. Darby, a subscriber to this Journal, formerly of Americus, Ga., has located at Columbus, Ga.

Dr. B. L. Wyman, Dean of the Birmingham Medical College, is at Tate Springs for a few weeks' rest.

Dr. Thos. D. Parke is spending a month in the city of Chicago, taking in the clinics and giving special attention to general medicine and pediatrics.

The Einstein Hospital at Brookwood, Ala., is completed and ready for the accommodation of patients. Dr. R. D. Jackson is the efficient superintendent, with Drs. Hitchcock and Sellers as attending physicians.

The question of ethics has and will always be a delicate one to handle. One of the noble characteristics of the average doctor is to abide the interpretation of a majority of his colleagues on moot questions of ethics.

The Tri-State Medical Society of Alabama, Georgia and Tennessee will meet in the city of Chattanooga, Tenn., October —, 1900. The President, Dr. R. R. Kline,, of Atlanta, Ga., is anxious for a large attendance from the three States. The program will show a list of interesting papers to be read and discussed.

Dr. Stubbs and his good wife showed us through their new residence on Twelfth avenue, South Highlands, a few days ago. There are hundreds of beautiful and attractive homes on the Highlands, but for location, design and finish there are none more beautiful and attractive than the home of Dr. Stubbs.

Doctor Samuel G. Gant, recently elected Professor of Rectal and Anal Surgery in the Post Graduate Medical School and Hospital, has removed from Kansas City, Mo., to No. 58 West 56th Street, New York City.

Messrs. Nabors, Morrow & Sinnige, of this city, whose large drug house was injured by fire a few months ago, have about completed the repairs and otherwise greatly beautified and improved their house, will soon be ready to reoccupy their former stand. This is one of the finest and most complete drug houses in the South, and well deserves the large patronage which they receive from the medical profession.

Dr. Lamphear, editor of the American Journal of Surgery and Gynecology, admits that he has made not a few enemies in the profession of St. Louis for the "ruff rider" way he has hit many of the so-called and would-be leaders of the profession of St. Louis, in exposing their hypocritical methods; but he has done good work and should be commended for it.

It may be a question of opinion about which honest doctors may differ, but having worked in and for the State Medical Association for more than fifteen years, and having been an observer of all, or at least many of the contentions which have arisen by these differences of opinion, we have come to be very decidedly of the opinion that the Association is stronger today than at any time in its history. Like other organizations controlled by men, it will have its ups and downs.

Marzo-Lithium given in teaspoonful doses in large draughts of cold or hot water or in butter milk is more frequently indicated, more economical, extensive in action and definite in results than the expensive mineral waters which enjoy such a wholesale reputation in the treatment of disorders of the renal function.—Medical Essays, 2 Encl.

New Orleans Polyclinic.—Physicians will find the Polyclinic an excellent means for posting themselves upon modern progress in all branches of medicine and surgery. The specialties are fully taught, particularly laboratory work. Fourteenth annual session opens November 12, 1900. For further information address Dr. Isadore Dyer, Secretary, New Orleans Polyclinic, New Orleans, La.

Chemical Food is a mixture of Phosphoric Acid and Phosphates, the value of which Physicians seem to have lost sight of to some extent, in the past few years. The Robinson Pettet Co., to whose advertisement (on page 6) we refer our readers, have placed upon the market a

much improved form of this compound, "Robinson's Phosphoric Elixir." Its superiority consists in its uniform composition and high degree of palatability.

UTERINE DERANGEMENTS.

I have used Aletris Cordial in my practice for over a year, and to say that I am pleased with it does not nearly express the degree of my satisfaction. Aletris Cordial fills a long-felt want with me. Symptoms attending uterine derangements have always been perplexing to physicians, but with this remedy the trouble vanishes as dew before the rising sun.—L. M. McLendon, M.D., Georgiana, Ala.

VIN MARIANI IN EXHAUSTION.

We have had occasion in numerous instances to administer "Vin Mariani" to business and professional men who complained of being gradually run down. The work of the office, the cares and worry entailed by business and the physical flaccidity brought on by overwork, all seemed to give way completely in a marvelously short space of time, despite the fact that the subjects continued uninterruptedly at their usual occupations. The notable fact to be observed is that in each instance the effect was permanent. But it must not be forgotten that, in order to make this result a lasting one, it is necessary to keep the patient upon a prolonged course in the use of "Vin Mariani." There is no doubt whatever that this preparation has proven itself a boon to mankind.—The St. Louis Medical and Surgical Journal, March, 1899.

SANMETTO IN HEMATURIA.

E. B. Gilbert, M. D., Ph. D., of Carbon, Texas, writing, says: "I used Sanmetto on a patient who had hematuria of long standing, and it gave the very best of results. The gentleman came back to my office about ten days after I prescribed Sanmetto for him, and said he had tried four doctors (naming them), and had gotten no good results, but that I had cured him. He being a very influential man, and I being a young physician, it has been worth quite a lot to e in the way of practice. I have on hand at present, three genito-urinary cases, who came to me for treatment, as a result of the success I had on that special patient, who would otherwise have gone to their family physicians."

EXPERIENCE WITH TANNIGEN.

Dr. C. M. Clark (Therapeutic Gazette, June 15, 1900) reports an interesting case of diarrhea of phthisis, with watery discharges from the bowels every hour or two, which had greatly diminished the patient's strength and vitality. After resorting to all the customary measures he made use of tannigen, which had the effect of reducing the passages to

two a day, and of rendering them more solid. Since observing the beneficial action of the drug in this case he has employed it extensively during the past year for the treatment of all watery discharges from the bowels in combination with subcarbonate of bismuth and resorcin. His cases comprised diarrhea of nervous or inflammatory origin, or resulting from acute dyspepsia due to over-feeding as well as over stimulation, which gives rise to flatuence with foul smelling serous discharges. According to his observations Dr. Clark believes tannigen is worthy of a more extended investigation by the profession.

One of the most significant signs of the times, in the industrial world, is the growing consideration of capital for the interests of labor and the growing consideration of labor for the interests of capital. While the laborer is worthy of his hire, the hirer is entitled to receive the very best service the laborer can give. In other words, the interests of labor and capital are interdependent; whatever affects the value of the one, instinctively affects the value of the other. In a broad sense there is no distinction between the labor of labor and the labor of capital. Both are laborers, and both entitled to equal rights, but both must work for the good of each or both must suffer.

It has taken long years of costly experience to learn these economic truths, but once learned there is established mutual respect and mutual co-operation in work whereby each factor receives a full and fair equivalent; and this once done, the existence of labor organizations becomes practically superfluous. It is worthy of note that in this country more than any other large manufacturing concerns are taking a personal interest in the welfare of their employes. These are corporations that have souls—the old saw, to the contrary notwithstanding—and their number is continually increasing.

In line doubtless with these advanced ideas it is pleasing to report that an annual picnic of the employes of the H. K. Mulford Co., was held on Saturday, June 23rd, 1900, at the extensive and beautiful Vaccine Farm of the company at Glenolden, Pa., the invitation being extended by the H. K. Mulford Co. Upwards of 300 left Broad Street Station in the morning on a special train. The events of the day comprised out of door sports, such as quoits, croquet, rope jumping, swinging, tether ball, foot ball, battledoor and shuttlecock, bean bags and dancing. This was followed by luncheon, and the afternoon was given over to special events, such as high kicking, running broad jump, 100 yard dash, 250 yard dash, jack, lantern rush, potato scramble and bicycle races. Handsome prizes were given the girl contestants.

The exciting event of the day, however, was the base ball game between the two rival teams of the employees, the "Nonpareil" (Blue and Yellow) and the "Resolute" (Crimson), the teams were:

Nonpareil (Yellow and Blue)—Thomas Stone, catcher; William P.

Stevenson, pitcher; William Bond, first base; Morris Josephson, second base; Harry Kirkbride, third base; Albert M. Johnson, shortstop; William C. McDole; right field; James H. Gotton, left field; Benjamin P. Duffield, centre field; Edward Prat, mascot.

Resolute (Crimson)—P. Young, catcher; J. Vogt, pitcher; C. E. Hayward, first base; C. O. Elgin, second base; A. F. Garton, third base; L. P. Faucett, shortstop; J. F. Lenny, left field; J. Wright, centre field; H. A. Fenner, right field; W. G. Tyson, umpire.

The "Crimson won; score, 12 to 7, and were presented with a beautiful solid silver loving cup to be kept and competed for year by year, by succeeding rival teams. After the game, supper was served and return was made to the city in the evening, thus ending as some of the more enthusiastic ones expressed it: "The jolliest and happiest picnic, and the best humored crowd of people we ever met."

The American Association of Obstetricians and Gynecologists will hold its thirteenth annual meeting in the Assembly room of the Galt House, Louisville, Ky., Tuesday, Wednesday and Thursday, September 18, 19 and 20, 1900, under the presidency of Dr. Rufus Bartlett Hall, of Cincinnati, Ohio.

The following named papers have been offered:

1. President's address, R. B. Hall, Cincinnati.
2. Ovarian fibroma—case with miscroscopical report—L. H. Laidley, St. Louis.
3. Cholelithiasis—with report of cases—H. E. Hayd, Buffalo.
4. Appendicitis during pregnancy, Charles G. Cumston, Boston.
5. Diagnosis of ectopic pregnancy before rupture, based on ten cases, J. F. Baldwin, Columbus.
6. Three cases of extrauterine pregnancy, with specimens, W. B. Dorsett, St. Louis.
7. The private hospital, Joseph Price, Philadelphia.
8. Paper (Title undetermined), E. F. Fish, Milwaukee.
9. Paper (Title undetermined), C. C. Frederick, Buffalo.
10. Extirpation of the rectum and sigmoid per vaginam, John B. Murphy, Chicago.
11. Paper (Title undetermined), H. O. Pantzer, Indianapolis.
12. Paper (Title undetermined), J. H. Carstens, Detroit.
13. The hymen—of what significance is its presence or absence in determining virginity, John Milton Duff, Pittsburg.
14. Paper (Title undetermined), W. P. Manton, Detroit.
15. Paper (Title undetermined), F. Blume, Pittsburg.
16. A satisfactory method for suspension of the uterus, Robert T. Morris, New York.
17. Paper (Title undetermined), H. W. Longyear, Detroit.

18. Some points regarding surgery of the gall-bladder, A. Vander Veer, Albany.

19. Surgery of the liver and bile ducts, W. G. Macdonald, Albany.

20. Observations respecting malignant disease of pelvic organs, Augustus P. Clarke, Cambridge.

21. Paper (Title undetermined), M. Rosenwasser, Cleveland.

22. Bilateral celiotomy and shortening of the round ligaments for complicated retroversion of the uterus, A. Goldspohn, Chicago.

23. Paper (Title undetermined), W. B. Chase, New York City.

24. Paper (Title undetermined), Charles A. L. Reed, Cincinnati.

25. Round ligament ventrosuspension of the uterus, D. Tod Gilliam, Columbus.

26. Paper (Title undetermined), L. S. McMurtry, Louisville.

The titles of papers are announced in the order of their reception. The permanent program will be classified and issued about August 25, after which date no further titles can be added or changes made in the printed program.

A cordial invitation is extended to the medical profession to attend the several scientific sessions of the association.

GYNAECOLOGY IN NERVOUS DISORDERS.

Many nervous troubles in women have their origin in affections of the genital organs, and hence in order to effect a permanent cure the condition of the latter must be carefully inquired into and corrected. Neurasthenia, epilepsy, various types of neuralgia, and even insanity, may be caused, or at any rate markedly aggravated by reflex irritation from uterine or ovarian disease. While in some instances cures have been reported from surgical measures in these cases, failures have been far more frequently observed, and especially is this true of cases of insanity. It is certain that much more promising results can be secured from topical medication of the affected genito-urinary tract in the earlier stages of the case when it first comes under the care of the general practitioner. A prompt resort to local treatment is much more likely to effect a cure than subsequent recourse to mutilating operations. A plan of topical medication that is particularly adapted for these patients, consists in the use of Micajah's Medicated Uterine Wafers. Their application is most simple, convenient, and cleanly that they are well tolerated even by the most sensitive patients. Under their use the congestion and inflammation of the affected parts gradually regain their normal tonicity. Conformably with the disappearance of the genital disease the nervous symptoms vanish and if this local treatment is combined with the use of nervous tonics, hygienic regulations, proper diet, etc., a complete restoration of health can usually be expected.

CLINICAL EXAMINATION OF THE URINE AND URINARY DIAGNOSIS.

A Clinical Guide for the Use of Practitioners and Students of Medicine and Surgery. By J. Bergen Ogden, M. D., Instructor in Chemistry Harvard University Medical School; Assistant in Clinical Pathology Boston City Hospital; Medical Chemist to the Corney Hospital; Visiting Chemist to the Long Island Hospital, Boston. Illustrated. Price, $3 net. Philadelphia: W. B. Saunders & Co.

This is an elegantly printed and well bound book of 416 pages, giving the chemistry of the urine and its relation to physiologic processes; the most approved working methods, both qualitative and quantitative; the diagnosis of diseases and disturbances of the kidneys and urinary passages. This book differs from other books of its character in that it deals extensively with the subject of urinary diagnosis. This makes of it a very valuable book, for it furnishes information which heretofore has been secured only by an extended search through various works on medicine, surgery, pathology and chemistry. It is worthy a place in any library, and those who purchase it will never regret the money which they invest in it.

A CASE OF HAEMORRHAGIC PURPURA COINCIDENT WITH LOBAR PNEUMONIA AND VACCINIA.

M. H. Dervaux (Journal des Sciences Medicales de Lille, May 19th) records the case of a child three-and-a-half years of age, which eight days after vaccination displayed around the pustules a large ecchymotic areola of about an inch and a quarter in diameter. Epistaxis set in, recurring nearly every day. The palatal vault was the seat of an elongated and very pronounced ecchymosis, slightly raised. Other patches were found on other parts of the body. The temperature was 104 degrees F. There were no digestive troubles, no inflation of the belly. The spleen was normal. There was slight cough but no morbid physical signs in the thorax. The child was taken into hospital with the provisional diagnosis of bilious hemorrhagic purpura and probable pneumonia. The subsequent course of the case justified the diagnosis. Recovery was natural. The author then discusses the various forms and

causes of purpura, dwelling especially on those that appear in the course of intoxications and infections. They are often observed in variola, scarlatina, measles, scurvy, typhoid, anginas, and severe jaundice. They are more rare in other affections, especially these present in this case. Up to 1897 only fourteen cases of purpura associated with vaccination had been published. It occurs principally among those predisposed to hæmorrhages. With pneumonia the association of purpura is rarer still. The author sums up as follows: 1. The appearance of infectious or toxic purpura may supervene in consequence of any toxi-infectious agent. 2. The nature of the agent is indifferent. Only the degree of infection needs consideration as an interesting factor. Localized infections as lobar pneumonia or broncho-pneumonia rarely dtermine its appearance. In the rare cases where it is so produced some adjuvant cause, e. g., vaccina, should be sought. The vascular alterations are, perhaps, due to a special product resulting from the effort of the organism at self-defence, rather than to destructive processes dependent upon the noxious agent. The hæmorrhagic action of therapeutic serums is an argumtnt in favor of this point of view.—N. Y. Medical Journal.

IF MONEY GREW ON TREES

And everybody owned an orchard, it would not make any difference how it was spent; but being as it is however, it makes an "awful" lot of difference whether you spend it wisely or unwisely.

YOU ARE INTERESTED

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Abstracts.

THE LAW OF DYING DECLARATIONS.[1]

By M. J. Sughrue, Esq., Boston.

The rules of evidence relating to the competency of statements of dying persons are a branch of the law with which physicians are frequently called upon to deal. A brief recital of some phases of this branch of the law, the scope of which has recently been extended by statutory enactment, is here attempted.

It is a general rule of law that statements made by third persons are not admissible in evidence, but are within the class of hearsay evidence, and are usually excluded. To the rule excluding hearsay evidence there are some exceptions; among them are dying declarations. Dying declarations are statements of material facts concerning the cause and circumstances of a homicide made by the victim, under the solemn conviction of impending death.

There are certain other declarations of dying persons which may not be admissible under the dying declaration rule, but which may be competent as part of the "res gestæ" (which are the circumstances of the transaction) on the ground of their natural, contemporaneous and explanatory connection with the main transaction. To be admissible under the latter rule, the declarations must be so nearly contemporaneous with the main fact as to be part of the "res gestæ," but need not have been made under a conviction of impending death. On the other hand, to be admissible under the dying declaration rule, the declaration need not be part of the "res gestæ," but must have been made in the consciousness and expectation of immediately approaching death.

Certain declarations made in the presence of the defendant are also competent for the purpose of showing defendant's response, when charged with causing the injury done to the deceased; the admissibility of this class of evidence depends upon the conduct, presence and response of the defendant. It is not necessary to the admissibility of dying declarations that the defendant should be present when they are made. Confessions, admissions and declarations are words frequently used interchangeably, but are each technical terms of distinct significance. A confession is a statement by a person of his agency or participation in a crime. An admission is an acknowledgement by a party to a suit of the truth of some incidental fact or facts. Confessions and admissions are made by parties to the indictment or suit; declarations are made by third parties.

An examination of the law of personal statements generally would involve a broad inquiry of no special interest from a medico-legal stand-

1. Read before the Massachusetts Medico-Legal Society, Feb. 7, 1900.

point and will not here be attempted; but that branch of this law which relates to dying declarations is alone considered.

A fuller statement of the rule relating to dying declarations than the one hereinbefore given is this: Where a defendant is on trial for homicide, the declaration of the person whom he is charged with having killed, if made while "in extremis" and under the solemnity of a conviction that he was at the point of death, and relating to matters of fact concerning the homicide which passed under his own observations, may be given in evidence.

The reason for the rule excepting dying declarations from the rule against hearsay evidence is that the solemnity of the circumstances under which such declarations are made, naturally constitute a guarantee of their truth equal to that which is afforded by the customary oath.

The further reason for the rule is in the necessity of the case; the victim of the homicide having passed away, and as there may be no other witness to the transaction, in order that the malefactor may not go unpunished, the strongest reasons of public policy require the admission of this testimony.[2] It was objected that the admission of this testimony contravened the constitutional provision that the accused should be confronted by his witness face to face, but Chief Justice Shaw declared that dying declarations are admissible, notwithstanding the Twelfth Article of the Declaration of Rights, that every subject shall have the right to meet the witnesses against him face to face, and this rule has been affirmed so often that the question is no longer open.[3]

In order that a dying declaration may be given in evidence the following conditions must be shown: That the declarant must have been conscious of impending death; that death must have occurred; that the statement must relate to the crime and be a description of the crime itself, and its manner of commission and of the person who committed it.

Even if the death was impending, if the declarant did not so believe, the declaration would not be competent; all hope of recovery must have been abandoned, and the declarant must be without hope or expectation of recovery.[4]

It is not necessary that declarant should be actually breathing his last; even though he lived some time the declaration is competent if made under a sense of impending death.

It has been held that statements made by the deceased while he yet entertained hopes of recovery are admissible if they were reaffirmed by him after he lost all hope.

FORM AND MANNER OF GIVING DECLARATIONS.

The form of the declaration is immaterial; it may be made orally or in writing. It is not necessary that a declaration should be expressed

2. Commonwealth v. Casey; 11 Cushing, 421.
3. Commonwealth v. Casey, 12 Cushing, 245.
4. Commonwealth v. Bishop. 165 Mass., 148.

in words; it may be communicated by signs. It was said by Chief Justice Shaw. in Commonwealth v. Casey cited above, that "If the injured party had but the action of a single finger, and with that finger pointed to the words 'yes' or 'no,' in answer to questions, in such a manner as to render it probable that she understood, and was at the same time conscious that she could not recover, then it is admissible evidence."

It will be sufficient if the declaration is taken down in writing by a bystander, and the writing then read over to the deceased, who assents to its terms and affixes his signature. But it is not essential that it be taken down in writing or that it be signed, but it will be useful so to do to preserve the evidence.

If the statement is carefully drawn and is a fair recital of the declarant's statement, it is not fatal to its competency if the exact words of the account of the case are not used. The declaration is admissible even if brought out by means of questions. It is not necessary that the declarant should be sworn. Dying declarations are admissible in favor of the accused as well as in favor of the Commonwealth.[5] But in each case the declarant must be the person who was the victim of the homicide.

CASES IN WHICH DYING DECLARATTIONS ARE ADMISSIBLE.

They are admissible only in cases of homicide, and in such additional cases as have been provided by statute.[6] By statute, abortion cases have been included.[7] Dying declarations are admissible only where the death of the declarant is the subject of the inquiry; they are not admissible to prove any other death. On an accident for murder it is not competent to introduce the statements of another person that he killed the deceased.[8] Defendant in a case tried in New York offered to introduce a letter which might be regarded as containing a confession of another person that he had committed the murder.[9]

Where three persons are jointly indicted for murder, and one of them is tried separately, it is not competent for him to give in evidence a conversation between the other two men when they were alone, inculpating themselves, and exculpating him from all participation in the crime.[10]

On an indictment for an assault with intent to murder, it was held that although the accused might exculpate himself by showing that another was guilty, yet this rule goes no farther in favor of the accused than to allow him to show another's guilt by some appropriate evidence directly connecting that person with the "corpus delicti." Therefore

5. Commonwealth v. Bishop; 165 Mass., 148.
6. Commonwaalth v. Thompson, 159 Mass., 56.
7. Statute of 1889, chapter 100, Laws of Massachusetts.
8. Wharton on Homicide. Section 603.
9. Greenfield v. People, 85 New York. 75.
10. United States v. Douglas, et al., 2 Blatchford, 207.

mere disconnected threats and declarations of third persons are inadmissible.[11]

Where the defence of a criminal charge is that a third person committed the offense, the confession of such third person, made after the offense and not part of the "res gestæ" is not admissible in evidence.[12]

The testimony of the declarant may be discredited as that of a witness taking the witness stand and testifying. It may be shown that the declarant was not mentally capable of making a statement, that his reputation for truth was bad. The statement of the dying person must be of matter competent; it must not be merely an expression of opinion, it must be a statement of facts which could be testified to if the declarant lived and was a witness at the trial.

It is competent for the defendant to introduce testimony to show that the deceased has made contradictory statements, and it is competent for the government to introduce testimony corroborative of the dying declaration.

In passing upon the weight to be given to dying declarations the jury have a right to consider all the circumstances under which it was made, and all the conditions by which the dying person was surrounded, and the state of mind of declarant, as shown by all that was said and done. Conduct, deportment, condition, all should be noted by the person who is to be a witness. Declarant's conduct in saying farewell to his relatives, in making such provision as is made by persons about to die; if the declarant is a Catholic, he receives extreme unction, this is of importance as indicating the state of mind. It will be found a most useful practical rule in these cases to first ascertain the state of mind of the dying person, and after that an expression by him that he has no hope of recovery, then to listen to a recital of the story of the crime.

It is because of a failure to proceed in this way that physicians frequently obtain an account of a crime which cannot be used in evidence, and it is more often because of inadvertence than want of knowledge; but the result is equally disastrous so far as a successful prosecution is concerned. Particularly is this true in abortion cases, in many of which, apart from the evidence obtained at the autopsy, there is no testimony save the dying statement of the person operated upon, which by reason of the carelessness or ignorance of the person hearing the statement is worthless evidence.

Another form of declaration of deceased persons made competent evidence by a recent statue which will be likely to call physicians into court to some extent hereafter is the law passed in 1898, Chapter 535 of Massachusetts Laws; this will be used in civil cases only; it is entitled, "An Act Relative to the Declarations of Deceased Persons." It reads:

11. State v. Baudet, 53 Ct., 536; West v. State, 76 Ala.
12. Peck v. State, 86 Tennessee, 259.

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"No declaration of a deceased person shall be excluded as evidence on the ground of its being hearsay, if it appears to the satisfaction of the judge to have been made in good faith before the beginning of the suit and upon the personal knowledge of the declarant.'"

In closing this paper it is proper, perhaps, to say that in speaking on the occasional failure of some person to comply with the exact legal requirement of the particular situation, it is with no desire to criticise, but on the contrary with a full recognition of the aid received from physicians and also of the fact that in most instances every requirement of the rules of evidence is complied with. The abortionist, the poisoner and the murderer would often have very little to fear from the best efforts of lawyers seeking to prevent crime were it not for the skill, the watchfulness and the fearlessness of the trained minds which trace the evidence of subtle poison or the course of the murderer's bullet. Without this assistance, in many instances the law would be helpless, and the fact that detection is made certain by the attainments of these scientific men restrains the criminal by bringing close to him the certainty of detection.—Boston Medical and Surgical Journal.

THE OFFICE OF MOTHERHOOD.

(By Ernest G. Mark, A. B., M. D., Louisville, Ky.):—In the appalling hush of that first white dawn when out of the womb of the universe was born the infant earth, motherhood became an existing condition—the primal condition—of life. And when, millions of years later, the earth no longer young, saw the first man stand reasoning and masterful in the presence of his servile and chattering half-brother, she felt the pangs of birth not to have been the sufferings inflicted by an aimless Chaos, but rather the self-imposed pain necessary to the advancement of some great master-scheme. The end she saw not; the purpose was progressive, not retrogressive, and, whatever the end, the steps were to be taken forward to a tomorrow, not backward to the yesterday. And so, through the entire natural order of things, the intelligence has set the motive of progression. Tennyson says:

"Science moves but slowly, slowly, creeping on from point to point:
Slowly comes a hungry people, as a lion, creeping nigher,
Glares at one that nods and winks behind a slowly dying fire.
Yet I doubt not through the ages one increasing purpose runs,
And the thoughts of men are widened with the process of the suns."

Evolution is no longer a vague term—a bugaboo to frighten ecclesiastics—but an established basis of scientific reasoning. Fortified with the knowledge of evolution, the physician is in a position to raise motherhood from a mere animal agency to the high office of a controlling factor in the battle for the survival of the fittest.

It is a deplorable fact that conception, in the vast majority of instances, is wholly accidental. Coitus is undertaken, not as an invitation to conception, but as a source of sensual satisfaction. The periodical molimen passes without an establishment of the menstrual flow, and the wife, resigning herself to the inevitable, enters upon a period of prospective motherhood. During the succeeding months of gestation, usually the only preparations made for the approaching parturition are the notification of the accoucheur and the making of the requisite clothing for the child.

Ordinarily, the physician lays down a few set hygienic rules to be followed during the ante-partum period. These rules are carelessly prepared and followed out equally as carelessly. The expected labor is undergone, and, after the customary daily visits for a week or ten days and a few words in regard to convalescence and the nursing period, all of which are set at naught by the sage advice of grandmothers, the physician passes out from the case.

There is an old adage which says that "there can't be too many babies in a family." This is heartily commended by all religious sects and tacitly sanctioned by the medical profession at large. Any prophylactic measures taken toward preventing conception are condemned by both the Church and the physician, and such measures are considered by some positively criminal, with the result that an appalling number of women, helpless in the face of such narrow reasoning, are embittered invalids by the time the menopause is reached, martyrs to a perverted idea of procreation.

I am well aware that what I am about to say will not meet with the approbation of many in the field of medicine. But if these same gentlemen will but look about them, not with the abiding faith of the religeuse, but with the unbiased eye of the scientist, they may find cause to alter their belief in the infallible intelligence of Nature. In the first place, the human race is and has ever been too prolific, and this prolificity is lessened as the parties to procreation become more intelligent. The poor are prolific simply on account of their lack of education. If the procreative function is to be raised to its proper plane, conception must no longer be considered the penalty exacted by Nature for the satisfaction of a sensual appetite and purely accidental. Rather it must be held as controllable and voluntary, the function that makes man a creator, not of mere flesh, but of a race that is to take up the work of progression toward the ideal.

Primarily, conception should never be an accident, but should be invited and expected at an opportune time. A time to be considered opportune should be when the physical condition of both husband and wife is at the best. Not only should the condition of health be a matter of consideration, but every element entering into the training of the expected

child should receive the most careful attention of the prospective parents. In other words, coitus should be undertaken in the hope of conception, husband and wife having in mind their ability to provide for progeny both as to environment and education.

Still further as regards conception. It is claimed, and with some reason, that children who are the offspring of an illegitimate passion have a strong inclination toward an intense vita sexuali, with an accompanying tendency toward sexual excesses and perversion. It can be safely asserted that illegitimate intercourse is never attended with a desire for progeny. Under such circumstances coitus is undertaken merely for the purpose of sensual gratification. Therefore the dominating factor in the conception of such a child is an animal desire, and it is but reasonable that such progeny should feel the heat of the same consuming flame that heralded the beginning of its physical life. This is certainly an argument in favor of the contention that conception should take place only when the idea of conceiving is present in coitu.

The diagnosis of pregnancy having been established, careful attention should now be given to pre-natal influences. These may be broadly divided into active and passive. Under the former head comes what we may consider as maternal influence. Maternal impressions are, of course, passive, though naturally such impressions may, and in the majority of instances perhaps do, become the bases of maternal influences. Such impressions are invariably passive per se.

Maternal influences are brought to bear by means of auto-suggestion. That is to say, the mother, following some trend of thought, consciously or unconsciously imparts auto-impressions which, becoming subjective in character, are transmitted to the fetus and are retained in after-life in its subjective consciousness.

This is the process of maternal influence as nearly as it can be stated. Character is probably transmitted in the same manner. The character-principles of the mother are imparted to the child, though the mode of transmissal is ordinarily merely subjective, the objective character of the mental process having taken place some time prior to pregnancy. The inheritance of the father's character by the child should be considered properly under the head of maternal impressions.

Maternal impressions are passive, the objective consciousness merely acting as a sense vehicle for the transmission of impressions to the subjective mentality. A picture is photographed upon the retina, and the impression so gained is hurried on to the subjective consciousness, and from thence the child becomes the recipient of a maternal impression. The strains of a piece of music falling upon the ear are projected in the same manner. And here it may be apropos to state that music is one of the most potent factors in the formation of maternal impressions. The voluminous, dominating Wagner, the delicate strength of Chopin,

the fiery intricacies of Liszt, the flowing purity of Beethoven, each in their characteristic way produce entirely different impressions. The drama, also, is a causative agent of very powerful impressions. Those causes giving rise to vivid impressions are also factors in producing strong maternal influences, exciting, as they do, objective reasoning.

The inheritance of the father's character by the child is best explainable through the agency of maternal impressions. The traits and principles of the mother lie latent in her subjective consciousness, their formation being complete before the period of motherhood. Her character is exercised subconsciously, the forces at work acting from within out. Each day coming in contact with the husband, his character and actions are impressed upon her from without in. Again, the old manner of producing male or female stock, so long in vogue among stockraisers and now being promulgated by certain physicians as "the law of vibrations," may have some influence, not only in the formation of the physical man, but also the mental. It is certainly as probable that at times the mentality is more acute and its vibrations are higher, and that this has an influence in forming mental man as that at times the vibrations of the physical entity are more dominant, and therefore impart their character to the physical man. And it is equally as probable that the higher rates of physical and mental vibrations are not necessarily coexistent. Again, it must not be forgotten that environment and training may undo all that pre-natal influence has accomplished; therefore the pre-natal influences, environment, and training must all advance along the same line, tending toward a progressive development.

To this end the sociologist, and especially the physician, must labor. The mother must be taught that her part in the scheme of progression is not one of mere reproduction of the species; that in the exercise of her procreative function she is to become not a breeder of the animal, but a creator of a future race of thinking, reasoning men and women, who are to play an equally important part in the race for the hidden goal. The prospective parents must be impressed with the power of pre-natal influence, beneficent or maleficent, as they may take it. All forces that are of value as causative agents of maternal influences or impressions should be utilized, in a full knowledge of their formative influence on the mentality of the child in utero. There should be a definite end aimed at, and all efforts should be directed in a progressive manner toward that end.

As a first step, the physician should use his influence toward dissipating the benighted idea that children are the gifts of an all-wise Providence, and that the woman who is the recipient of the greatest number of such gifts is the most blessed by this infallible guide. Thousands of women are sent to a premature grave every year as a result of a perverted idea of procreation, and thousands are existing in a state

of living death from the same cause. The happiness of more homes is wrecked from the blight of too many children than from the lack of progeny.

Much stress is laid upon the duty the child owes the parent, and very little upon that the parent owes the child. Children are not brought into the world of their own volition. It is safe to say that could each person control their entrance into the world, the globe would be populated by a race of fools and martyrs. The duty of the parent to the child is more sacred than that owed by the child to the parent. The parents who bring into being a life for whom they can not provide, and to whom they can not give the training and attention necessary for its advancement, commit a crime more to be condemned than the act of a husband and wife who, recognizing their inability to give to a child what it has the right to demand of them, refuse to bring a child into the world.

When the man and the woman shall have been taught that conception should not be accidental; that it should take place as the result of a prearranged plan and at a suitable time; that there is a sacred duty which they owe the child of their conceiving, and that to this end they should utilize the pre-natal factors in the child's development, as well as those that are post-natal, then, and not till then, will motherhood be placed upon the high plane to which it has a holy right—that of a creator of an entity in whom the God-like attributes are manifested dominant of the flesh.

THE MEDICAL ASPECT OF THE CHINESE CAMPAIGN.

The Chinese situation is one which will tax to the full, far more than any recent war, the resources and expansiveness of the medical service of the respective forces engaged. Those sentimentalists who have been crying out over the horrors of war, as depicted in the inevitable suffering that must follow, and the hardships that must be endured by the armies of civilized powers, as we Westerners understand civilization, will possibly learn by comparison how much we have to be thankful for in modern civilized warfare when they glean from the happenings in China what the state of medical aid was among even European nations in times not very far removed.

In the Spanish-American, in the South African wars, humanity to the wounded on either side has been a matter of course in accordance with the accepted principles of modern warfare. If retreat was unavoidable, the wounded might safely be left to fall into the hands of the enemy, for it was full well known that, once placed by their condition out of the position of active foes, they would meet with the same kindly care and attention as if they were in the hands of their own comrades. Great Britain, perhaps, with its constant and everlasting experience of war-

fare on a small scale with uncivilized tribes, has, or ought to have, a greater knowledge than other nations of what measures will be necessary to ensure protection, as well as adequate care and attention, to those who may be wounded or otherwise placed hors de combat in the present campaign in China. Complaints of inhumanity in firing on the Red Cross, etc., have been freely bandied about by both sides in the Spanish-American and in the South African wars, but, save for a few isolated instances in which the offenders were absolutely defying the spirit and intentions of their own side with that impunity which the confusion of things obtaining in war renders almost unavoidable, it is safe to declare that on both sides the transgressions were inadvertent and due to misapprehension, not to malignity. But in China all that is different. There the Red Cross commands no respect whatever. Even Turkey will treat the Red Cross with the same respect which it demands for the Red Crescent. But in China cruelty and atrocity may be looked for as the regular thing in regard to such as may chance to find themselves in the enemy's hands. Even the hospitals will be no longer "non-combatant" there, but must be turned into armed camps ready to defend themselves, even to the extent of that best of defences, under many circumstances, counter-attack. The recent passages of arms, moreover, are beginning to rouse the world to the idea which only few seem hitherto to have entertained, viz., that progress in both measures and implements of destructiveness has not been confined to one or two nations. With modern methods and modern weapons, the world is waking up to what a few "cranks" have been eliciting contemptuous scorn for stating, viz., that the invincible nations are invincible no longer, and that even foes of the "old-fogy" type may be perilously "up to date" when it comes to blows. We underrated the resistance in the Philippines; Fate certainly favored us in the Spanish war, or it might have been found that we had underrated our enemy there; the British undoubtedly underestimated their South African foes; and all the nations, except, perhaps, the Japanese, who have had some practical experience with them, appear even yet to be underestimating the military resources of the Chinese.

As to the question of disease, which in warfare has from old times been said to be more fatal than the enemy's weapons, the same mistake has occurred all round. The experience of the French in Madagascar did not teach us wisdom, neither did our experience, coupled with that of France, make the British foreseeing enough to provide against the appalling affliction from disease in South Africa. That France, at least, has learned something from her Madagascar experience is shown by the very admirable circular, reproduced in another column, which has been issued by her Minister of Marine. The French have had some experience in Chinese campaigning also in the Tonking, so that their official advice to their own troops is worthy of weighty consideration.—Editorial in N. Y. Medical Journal.